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A G E N D A

DECEMBER 6—10, 1954

A G E N D A

FIFTY-THIRD ANNUAL CONFERENCE

of

THE SURGEON GENERAL

of the

PUBLIC HEALTH SERVICE

and

THE CHIEF

of the

CHILDREN'S BUREAU

with

THE STATE AND TERRITORIAL HEALTH OFFICERS

THE STATE MENTAL HEALTH AUTHORITIES

and

REPRESENTATIVES OF STATE HOSPITAL SURVEY AND CONSTRUCTION AGENCIES

December 6-10, 1954

Department of Health, Education, and Welfare Bldg.

Washington, D. C.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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Mental Health Committee

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Special Committee on Migrant Labor

FOR YOUR INFORMATION

MEETING ROOMS

General sessions take place in the Auditorium (first floor) of the Department of Health, Education, and Welfare Building, North, 4th and Independence Avenue, S. W., Washington, D. C. and in Wilson Hall, National Institutes of Health, Bethesda, Maryland. Executive sessions are held in the rooms listed on the Schedule of Events.

Committees meet in the rooms listed on the Committee Agenda.

HEADQUARTERS

Official conference headquarters for the Association of State and Territorial Health Officers is the Washington Hotel, 15th and Pennsylvania Avenue, N. W.

REGISTRATION AND STENOGRAPHIC SERVICES

Registration. The registration desk is located in the main lobby of the Department Building facing the Auditorium entrance on the first floor. Check here Monday, December 6th, to register and pick up your Conference badge. Late registration is here, too.

Stenographic service. Arrangements for stenographic service may be made at the registration desk.

SOCIAL EVENTS

Association dinner is scheduled for Tuesday night, December 7, 7:00 P.M. at the Washington Hotel. A luncheon is scheduled on Wednesday, December 8, 12:30 P.M. at District General Hospital. Other social events will be announced at the beginning of the Conference.

INFORMATIONAL SHEET FOR OUT-OF-TOWN VISITORS OF THE HEALTH, EDUCATION, AND WELFARE BUILDINGS

OFFICE HOURS: 9:00 a.m. - 5:30 p.m.

INFORMATION DESK: Located in the main lobby of Health, Education, and Welfare, North Building, 330 Independence Avenue, S.W.

CAFETERIAS: Government cafaterias, located in the basement of the North and South Buildings.

	North Bldg.	South Bldg.
Breakfast	7:30 - 8:45	7:10 - 8:45
Snacks	10:00 - 2:30	10:00 - 3:30
Lunch	11:00 - 2:00	11:00 - 1:30
Dining Room (official)	11:30 - 1:00	11:30 - 1:30

Also, several snack stands operated by the blind are available in the basement of the North and South HEW Buildings. The snack bar located near the entrance to the tunnel of the North Building remains open from 8:00 a.m. to 9:00 p.m.

TRANSPORTATION:

Street cars and buses: Fare - one trip 20¢; tokens 5 for 80¢; no charge for transfers; weekly permit 75¢ entitles person to unlimited number of rides at the rate of 10¢ each.

Taxicabs: Best service available on the corner of Fourth Street(West) end of North Building parking area. Fares range from 40¢ and up for individual according to zone -- 30¢ and up for each individual riding in group.

Shuttle Service between HEW and NIH:

Incoming (Leaving Bethesda Bldg. T6)	Outgoing (Leaving HEW loading platform between North & South Bldgs.)
8:45	8:45
10:00	10:15
12:05	11:10
1:05	1:15
2:25	2:25
3:55	3:40

To Union Station: #30 street car to Capitol Hill, transfer at Library of Congress to #90 car.

To National Airport: Arrange with airline ticket office to meet airport limousine - fare $1.25. To airport via taxicab $1.50 per person or $1.00 group riding.

To White House, Treasury, and Downtown Area: #30 street car (Friendship Heights) on opposite side of street in front of North Building.

To Capitol, House and Senate Office Buildings, Congressional Library and Supreme Court: #30 street car (17th and Penna. Ave., S.E.) at stop directly in front of North Building.

Note: PHS motor pool is no longer available.

SCHEDULE OF EVENTS

When		Where	What
Dec. 5, Sun.	12:30 pm	Washington Hotel District Room	Luncheon meeting of the Civil Defense Special Committee with FCDA, CB and PHS officials
	2:00 pm	Washington Hotel Capital Room	Migrant Labor Special Committee
	4:00 pm	Washington Hotel District Room	Indian Affairs Special Committee
	7:00 pm	Washington Hotel District Room	Meeting of the Executive Committee, Chairmen of Standing Committees, Vice-Chairmen of Hospital and Mental Health Committees, CB and PHS liaison and other representatives
Dec. 6, Mon.	9:00 am-10:00 am	HEW Auditorium	Executive Session of the Association, Hospital Authorities, and Mental Health Authorities
Meetings of Standing Committees on Conference and Association Business			
	10:00 am-12:30 pm	Room 5051-North	Federal Relations Committee
		Room 5022-South	Environmental Sanitation Committee
		Room 3065-South	Hospital Committee
		Room G-743A-North	Infectious Diseases Committee
		Room G-759A-North	Maternal and Child Health Committee
		Room G-751-North	Mental Health Committee
		Room G-755-North	Special Health and Medical Services Committee
	12:30 pm-2:00 pm		Lunch
		To be announced	Luncheon meeting of the Executive Committee with the Chief, BSS
	2:00 pm-5:30 pm	(Same as morning room assignments)	Standing Committee meetings
Dec. 7, Tues.	9:00 am-11:00 am	HEW Auditorium	General Session of Conference - CB and PHS Program: Mrs. Oveta Culp Hobby, Sec'y, HEW; Dr. Leonard Scheele, Surg. Gen'l, PHS; Dr. Martha Eliot, Chief, CB.

When		Where	What
Dec. 7, Tues. (cont'd)	11:10 am-3:00 pm	Room 5051-North	Executive Session - Hospital Survey and Construction Authorities
	To be determined	To be announced	Executive Committee luncheon meeting with Chief of CB, Surgeon General, and other CB and PHS representatives
	1:00 pm-3:00 pm		Guest program - individual appointments with CB staff as requested by guests
	3:00 pm-5:00 pm	Room 5022-South	Guest program - International Cooperation for Improved Health, Dr. H. Van Zile Hyde and staff, Division of International Health
	3:00 pm-5:30 pm	Room 5051-North	Executive Session - Mental Health Authorities
	7:00 pm	Washington Hotel	Banquet of the Association of State and Territorial Health Officers - Speaker, Dr. Arthur P. Noyes, President, American Psychiatric Association
Dec. 8, Wed.	9:00 am-10:30 am	Room 5051-North	Executive Session of the Association - Program on Administration: Training, Dr. Thomas R. Hood; Budget Presentation, Dr. J. W. R. Norton; Non-Medical Administrative Personnel in Public Health, Dr. Malcolm H. Merrill
	10:45 am-12:30 pm	HEW Auditorium	General Session of the Association - Program on Administration: Research in Public Health Methods and Program Evaluation, Dr. Herman E. Hilleboe; Health Councils, Dr. Russell E. Teague
	12:30 pm-2:00 pm	District General Hospital	Luncheon - Association Members and Guests

When		Where	What
Dec. 8, Wed. (cont'd)	2:00 pm-4:00 pm	Room 5022-North	Guest Program - Demonstrations and Exhibits, Division of Special Health Services: Heart Sounds, Breath Sounds, Diabetes Detection
	2:00 pm-5:30 pm	Room 5051-North	Executive Session of the Association - Reports from Association representatives to outside agencies
Dec. 9, Thurs.	9:00 am-10:30 am	Wilson Hall, Building 1 National Institutes of Health	General Session of the Conference - CB and PHS Program
	10:45 am-12:00 noon	Clinical Center	Guest Program - Guided Tour of Basic and Clinical Research Facilities
		Wilson Hall, Building 1, National Institutes of Health	Executive Session of the Association - Consideration of Committee Reports
	1:30 pm-5:00 pm	Wilson Hall, Building 1, National Institutes of Health	Executive Session of the Association - Consideration of Committee Reports
Dec. 10, Fri.	9:00 am-10:00 am	HEW Auditorium	General Session of Conference - Reports to the Surgeon General, PHS and Chief, Children's Bureau
	10:00 am-12:00 noon	Room 5051-North	Business Session of the Association
	12:30 pm	To be announced	Executive Committee of the Association of State and Territorial Health Officers, outgoing chairmen of Standing Committees, outgoing Vice-Chairmen of Hospital and Mental Health Committees meeting with the Surgeon General, PHS, and the Chief, CB, and other PHS and CB representatives

ROSTER
OF
STATE AND TERRITORIAL HEALTH OFFICERS
STATE MENTAL HEALTH AUTHORITIES
STATE HOSPITAL PLANNING AND CONSTRUCTION AUTHORITIES

November - 1954

ALABAMA

SHO: D. G. Gill, M.D.
State Health Officer
State Department of Health
Montgomery 4, Alabama

ALASKA

SHO: C. Earl Albrecht, M.D.
Commissioner of Health
Territorial Department of Health
Alaska Office Building
Juneau, Alaska

ARIZONA

SHO: Clarence G. Salsbury, M.D.
Commissioner of Public Health
State Department of Health
Phoenix, Arizona

ARKANSAS

SHO: John T. Herron, M.D.
State Health Officer
State Board of Health
Little Rock, Arkansas

CALIFORNIA

SHO: Malcolm H. Merrill, M.D.
Director of Public Health
State Department of Public Health
668 Phelan Building
San Francisco 2, California

MHA: Walter Rapaport, M.D., Director
State Department of Mental Hygiene
Sacramento, California

COLORADO

SHO: R. L. Cleere, M.D.
Executive Director
State Department of Public Health
414 State Office Building
Denver 2, Colorado

CONNECTICUT

SHO: Stanley H. Osborn, M.D.
Commissioner of Health
State Department of Health
Hartford 15, Connecticut

DELAWARE

SHO: Floyd I. Hudson, M.D.
Executive Secretary
State Board of Health
Dover, Delaware

MHA: M. A. Tarumianz, M.D.
Superintendent
State Board of Trustees
Delaware State Hospital
Farnshurst, Delaware

DISTRICT OF COLUMBIA

SHO: Daniel L. Seckinger, M.D.
Director of Public Health
District of Columbia Health Department
Washington 1, D. C.

FLORIDA

SHO: Wilson T. Sowder, M.D.
State Health Officer
State Board of Health
Post Office Box 210
Jacksonville 1, Florida

Key: SHO - State Health Officer
MHA - State Mental Health Authority
HCA - State Hospital Planning and Construction Authority

FLORIDA - Continued

HCA: T. W. Witherington, Director
State Improvement Commission
Post Office Box 930
Tallahassee, Florida

GEORGIA

SHO: T. F. Sellers, M.D., Director
Department of Public Health
State Office Building
Atlanta 3, Georgia

HAWAII

SHO: Richard K. C. Lee, M.D., President
Board of Health
Territory of Hawaii Department of Health
Honolulu 1, Hawaii

IDAHO

SHO: L. J. Peterson, M.S.P.H.
Administrative Director
Department of Public Health
Boise, Idaho

ILLINOIS

SHO: Roland R. Cross, M.D., Director of Public Health
Department of Public Health
Springfield, Illinois

MHA: Otto L. Bettag, M.D., Director
State Department of Public Health
Springfield, Illinois

INDIANA

SHO: Andrew C. Offutt, M.D.
Secretary & Commissioner
State Board of Health
1330 West Michigan Street
Indianapolis 7, Indiana

MHA: Margaret Morgan, M.D., Commissioner
Division of Mental Health
Department of Health
1330 West Michigan Street
Indianapolis 7, Indiana

IOWA

SHO: Edmund G. Zimmerer, M.D.
State Commissioner of Health
State Department of Health
1027 Des Moines Street
Des Moines 19, Iowa

MHA: Wilbur Miller, M.D., Director
Psychopathic Hospital
State University of Iowa
Iowa City, Iowa

KANSAS

SHO: Thomas R. Hood, M.D.
Executive Secretary
State Board of Health
Topeka, Kansas

KENTUCKY

SHO: Bruce Underwood, M.D.
Commissioner of Health
State Department of Health
620 South Third Street
Louisville 2, Kentucky

MHA: Frank M. Gaines, M.D, Commissioner
State Department of Mental Health
Louisville 2, Kentucky

LOUISIANA

SHO: S. J. Phillips, M.D., President
State Board of Health and State Health Officer
State Department of Health
Civil Courts Building
New Orleans 7, Louisiana

MHA & HCA: Edward D. Grant, Ph.D., Director
State Department of Institutions
Baton Rouge, Louisiana

MAINE

SHO: Dean H. Fisher, M.D., Interim Commissioner
Department of Health & Welfare and Director, Bureau of Health
Augusta, Maine

MARYLAND

SHO: Robert H. Riley, M.D., Director of Public Health
State Department of Health
2411 North Charles Street
Baltimore 18, Maryland

MASSACHUSETTS

SHO: Samuel B. Kirkwood, M.D.
Commissioner of Public Health
Department of Public Health
546 State House
Boston 33, Massachusetts

MHA: Jack R. Ewalt, M.D., Commissioner of Mental Health
State Department of Mental Health
Boston, Massachusetts

MICHIGAN

SHO: Albert E. Heustis, M.D.
Commissioner of Health
Department of Health
Old Dewitt Road
Lansing 4, Michigan

MHA: Charles F. Wagg, Director
Department of Mental Health
Lansing, Michigan

HCA: Jacques G. DeLaurier, Director
Office of Hospital Survey and Construction
Lansing, Michigan

MINNESOTA

SHO: A. J. Chesley, M.D.
Secretary and Executive Officer
Department of Health
Campus, University of Minnesota
Minneapolis 14, Minnesota

MHA: Jarle Leirfallom
Commissioner
State Department of Public Welfare
410 Globe Building
St. Paul, Minnesota

MISSISSIPPI

SHO: Felix J. Underwood, M.D.
Secretary and Executive Officer
State Board of Health
Jackson 5, Mississippi

HCA: Foster L. Fowler
Executive Director
State Commission on Hospital Care
Jackson 5, Mississippi

MISSOURI

SHO: James R. Amos, M.D.
Director of Health
Division of Health
Department of Public Health and Welfare
Jefferson City, Missouri

MONTANA

SHO: G. D. Carlyle Thompson, M.D.
Executive Officer and Secretary
State Board of Health
Helena, Montana

MHA: R. J. Spratt, M.D., Superintendent
Montana State Hospital
State Department of Mental Hygiene
Warm Springs, Montana

NEBRASKA

SHO: E. A. Rogers, M.D.
Director of Health
Department of Health
1010 State Capitol
Lincoln 9, Nebraska

NEVADA

SHO: Daniel J. Hurley, M.D.
Acting State Health Officer
State Department of Health
Carson City, Nevada

NEW HAMPSHIRE

SHO: John Samuel Wheeler, M.D.
State Health Officer
State Health Department
Concord, New Hampshire

NEW HAMPSHIRE - Continued

MHA: Anna L. Philbrook, M.D., Director
Mental Hygiene and Child Guidance Clinics
State Commission of Mental Health
274 Pleasant Street
Concord, New Hampshire

NEW JERSEY

SHO: Daniel Bergsma, M.D.
State Commissioner of Health
State Department of Health
Trenton 7, New Jersey

MHA: & HCA F. Lovell Bixby
Acting Commissioner
State Department of Institutions and Agencies
Trenton 7, New Jersey

NEW MEXICO

SHO: Gerald R. Clark, M.D., Director of Public Health
Department of Public Health
Santa Fe, New Mexico

NEW YORK

SHO: Herman E. Hilleboe, M.D.
Commissioner of Health
State Department of Health
Albany 1, New York

MHA: Newton J. T. Bigelow, M.D.
Commissioner
State Department of Mental Hygiene
Albany, New York

HCA: John J. Bourke, M.D.
Executive Director
State Joint Hospital
Survey and Planning Commission
Albany 1, New York

NORTH CAROLINA

SHO: J. W. R. Norton, M.D.
Secretary and State Health Officer
State Board of Health
Raleigh, North Carolina

NORTH CAROLINA - Continued

HCA: John A. Ferrell, M.D.
Executive Secretary
Medical Care Commission
Post Office Box 1880
Raleigh, North Carolina

NORTH DAKOTA

SHO: Jerome H. Svore, M.D.
Director of Public Health
State Department of Health
Bismarck, North Dakota

Russell O. Saxvik, M.D.
Superintendent, State Hospital
Jamestown, North Dakota

OHIO

SHO: Ralph E. Dwork, L.R.C.P. & S.
Director of Health
Department of Health
306 Ohio Departments Building
Columbus 15, Ohio

MHA: John D. Porterfield, M.D., Director
State Department of Mental Hygiene and Correction
1206 Ohio Departments Building
Columbus 16, Ohio

OKLAHOMA

SHO: Grady F. Mathews, M.D.
Commissioner of Health
State Department of Health
3400 North Eastern
Oklahoma City 5, Oklahoma

OREGON

SHO: Harold M. Erickson, M.D.
State Health Officer
State Board of Health
State Office Building
1400 S. W. Fifth Avenue
Portland, Oregon

PENNSYLVANIA

SHO: Russell E. Teague, M.D.
Secretary of Health
Department of Health
Harrisburg, Pennsylvania

PENNSYLVANIA - Continued

MHA: & HCA Alan D. Reynolds, Secretary of Welfare
State Department of Welfare
Harrisburg, Pennsylvania

PUERTO RICO

SHO: Juan A. Pons, M.D.
Secretary of Health
Puerto Rico Department of Health
San Juan 18, Puerto Rico

RHODE ISLAND

SHO: Edward A. McLaughlin, M.D.
Director of Health
Department of Health
Providence 2, Rhode Island

MHA: Edward P. Eridy, Director
State Department of Social Welfare
40 Fountain Street
Providence, Rhode Island

SOUTH CAROLINA

SHO: G. S. T. Peeples, M.D.
State Health Officer
State Board of Health
Wade Hampton Office Building
Columbia 1, South Carolina

MHA: W. P. Beckman, M. D., State Director of Mental Health
State Mental Health Commission
South Carolina State Hospital
Columbia, South Carolina

SOUTH DAKOTA

SHO: G. J. Van Heuvelen, M.D.
State Health Officer
State Department of Health
Pierre, South Dakota

TENNESSEE

SHO: R. H. Hutcheson, M.D.
Commissioner of Public Health
Department of Public Health
420 Sixth Avenue, North
Nashville 3, Tennessee

TENNESSEE - Continued

MHA: Cyril J. Ruilmann, M.D., Commissioner
State Department of Mental Health
Nashville, Tennessee

TEXAS

SHO: Henry A. Holle, M.D.
State Health Officer
State Department of Health
Austin 14, Texas

UTAH

SHO: George A. Spendlove, M.D.
Director of Public Health
State Department of Health
130 State Capitol
Salt Lake City 1, Utah

VERMONT

SHO: R. B. Aiken, M.D.
State Health Commissioner
Department of Health
Burlington, Vermont

VIRGIN ISLANDS

SHO: Roy A. Anduze, M.D.
Commissioner of Health
Virgin Islands Department of Health
Charlotte Amalie, Saint Thomas
Virgin Islands

VIRGINIA

SHO: Mack I. Shanholtz, M.D.
State Health Commissioner
Department of Health
Richmond 19, Virginia

MHA: Joseph E. Barrett, M.D.
Commissioner
State Department of Mental Hygiene and Hospitals
Richmond 9, Virginia

WASHINGTON

SHO: John A. Kahl, M.D.
Acting Director of Health
State Department of Health
Smith Tower
Seattle 4, Washington

WEST VIRGINIA

SHO: N. H. Dyer, M.D.
State Director of Health
State Department of Health
Charleston 5, West Virginia

WISCONSIN

SHO: Carl N. Neupert, M.D.
State Health Officer
State Board of Health
State Office Building
Madison 2, Wisconsin

WISCONSIN - Continued

MHA: John W. Tramburg, Director
State Department of Public Welfare
Madison 2, Wisconsin

WYOMING

SHO: Franklin D. Yoder, M.D.
Director of Public Health
State Department of Public Health
State Office Building
Cheyenne, Wyoming

December 6-10, 1954

CONFERENCE RULES

ATTENDANCE AT COMMITTEE MEETINGS

Committee meetings are essentially closed sessions with attendance limited to:

1. State representatives and their alternates.

2. Designated representatives from the Children's Bureau and the Public Health Service.

3. Other persons invited by the Association, the Public Health Service, or the Children's Bureau to participate in the discussion of an item of committee business.

Voting at committee sessions is limited to designated members of the committee and alternates who have been authorized to sit on the committee in the absence of the designated members. Alternates will be seated on the committee through written notification to the chairman from the designated members.

Executive sessions of the Association are closed meetings with attendance limited to:

1. State health officers and State representatives of mental health authorities and hospital authorities.

2. Staff members of the three State authorities participating in the Conference.

3. Guests invited by the President of the Association.

Action of the Association and State Health Officials in Conference assembled will be released to the press; however, agenda items and reports will not be released for publication prior to such action.

ASSISTANCE TO COMMITTEE CHAIRMEN

The chairman of each committee will designate one member of the committee to maintain records and to prepare a report in accordance with the prescribed format. Methods which have been used successfully by various committees to discharge this responsibility are:

1. The chairman of the committee handles the records, while the vice-chairman handles the meeting.

CONFERENCE RULES - Continued

2. One of the members of the committee is designated as the secretary.

3. The vice-chairman serves as secretary.

Liaison between the committee chairmen and the Public Health Service and the Children's Bureau will be maintained by a liaison representative from the Public Health Service or the Children's Bureau. Committee chairmen should feel free to consult with this representative regarding resources for consultation on any subject falling within the purview of the committee as well as the conduct of the committee meeting.

AGENDA ITEMS

Early in July the Secretary of the Association will remind health officers to submit proposed agenda items in the prescribed form to the Division of General Health Services of the Public Health Service for incorporation into a tentative agenda to be reviewed by the Executive Committee.

The agenda for the various committees will be developed during the meeting of the Executive Committee and committee chairmen on October 8 and 9. The agenda of each committee will be composed of items submitted by States as assigned during the October meeting and items submitted by the Public Health Service and the Children's Bureau. All items will be stated in terms of (1) the action desired and (2) a supporting statement. (See Form 1, attached.) Each State participant will have a copy of agenda material for all committees at least a month before the December meeting.

To the maximum extent possible, the agenda items which appropriately come within the jurisdiction of more than one committee will be referred to both committees in the formal agenda material. When, however, in the opinion of a committee chairman, an item which should be considered by another committee has not been referred to that committee, he should take steps to see that it is done. Committees to which items have been referred jointly should arrange for the development of a recommended Conference or Association action which has the approval of both committees, rather than submit separate reports.

Before the committee meetings, definite times will be established for discussion of the agenda items for which special consultation is anticipated so that such special consultants will not have to remain during the entire deliberations of the committee. This time schedule will be available to committee chairmen and consultants in advance of the meeting date. Other items on the agenda will be discussed as they appear in the agenda booklet.

Committee chairmen may, if they wish, take up for consideration items not on the formal agenda which may be brought to the attention of the committee during the meeting by committee members or consultants. Such items should be considered only after prepared items receive consideration.

Committee chairmen may also, if they wish, allow time for the review of progress reports on recommendations made at the previous Conference.

DISTINCTION BETWEEN BUSINESS OF THE CONFERENCE AND OF THE ASSOCIATION

In reporting to the executive session, the committee chairmen will designate each recommendation as coming within the purview either of the Conference called by the Surgeon General of the Public Health Service and the Chief of the Children's Bureau, or of the Association of State and Territorial Health Officers. In general, this differentiation will be made as follows:

1. Recommendations which relate to functions or activities which are the official responsibility of the Public Health Service or the Children's Bureau will be designated as Conference proposals.

2. All other recommendations will be considered as Association proposals; e.g., items which relate to functions or activities which are primarily the responsibility of another government agency or voluntary association, items which relate to legislative recommendations, or items which are concerned with the transfer of functions.

Any items not on the formal agenda concerning which a committee recommends action should likewise be identified by the committee chairman as Conference or Association business.

FORMAT OF COMMITTEE REPORTS

Committee reports should be kept short. Except for the most unusual circumstances, the reports should be limited to action which the committee recommends be taken. Discussions of background, progress, philosophy, etc. should be contained in very brief supporting statements. The committee chairman will have an opportunity to amplify this type of material during the deliberations in the executive session.

A minority report from the committee to the Association is in order if there is a definite difference of opinion among the committee members as to recommended action.

Committee chairmen should segregate into separate sections of their reports those recommendations which are for action by the Conference and those that are for action by the Association. It is also important that each committee recommendation specifically indicate what action is recommended and what organization or individual is responsible for taking the recommended action.

Committee reports will consist of brief transmittals identifying recommendations for adoption by the Conference and by the Association. The recommendations will be typed on prescribed forms and attached to the transmittals. (See Form 2, attached.) Reports should be cleared with the Secretary of the Association for conformity to prescribed format before final typing.

CONFERENCE RULES - Continued

TIMING OF COMMITTEE REPORTS

Committee sessions will be concluded on the first day of the session. The report should be written or dictated to the secretary immediately. The Public Health Service will duplicate the reports and have them available in sufficient copies for all State representatives prior to the executive sessions at which they will be considered for formal Conference or Association action.

CONTROVERSIAL ITEMS

Items which involve any significant difference of opinion among committee members or between a committee and the Public Health Service or Children's Bureau position should be brought to the attention of the Executive Committee by committee chairmen prior to noon of the second day.

A short meeting has been scheduled by the Executive Committee with representatives of the Public Health Service and Children's Bureau at noon on the second day. This session will permit further clarification of all items brought up in committee meetings before the committee reports are finally acted upon in executive session on the afternoons of the second and fourth days and on the fifth day.

RESOLUTIONS

Resolutions should be submitted by mail to Dr. Bruce Underwood, Chairman, Resolutions Committee before the December meeting. Resolutions may be proposed from the floor at the executive session, Monday, December 6, 1954. After that time resolutions shall come from committees only.

Proposed resolutions received by the Resolutions Committee will be referred to the appropriate standing committee or committees for recommendation as to Conference or Association action. Only in emergencies may resolutions be submitted to the Executive Committee for review and referral to the Resolutions Committee.

Each committee may make oral commendations to consultants. Written commendations should not be included in the report of the committees but should be forwarded to the Resolutions Committee to be incorporated in a general resolution.

Form 1

Proposed Agenda Item for _____ Conference
(year)

Submitted by: _____
(State Agency or Federal Division)

Title:

Action desired:

Supporting statement:

FORM 2

COMMITTEE RECOMMENDATION ON AGENDA ITEM

SUBMITTED BY:

CIVIL DEFENSE	☐	MATERNAL AND CHILD HEALTH	☐
FEDERAL RELATIONS	☐	MENTAL HEALTH	☐
ENVIRONMENTAL SANITATION	☐	MIGRANT LABOR	☐
HOSPITAL	☐	SPECIAL HEALTH AND MEDICAL SERVICES	☐
INDIAN AFFAIRS	☐	_____	☐
INFECTIOUS DISEASES	☐	_____	☐

RECOMMENDED FOR ADOPTION BY:

CONFERENCE:
1. STATE AND TERRITORIAL HEALTH OFFICERS
2. REPRESENTATIVES OF STATE AND TERRITORIAL HOSPITAL SURVEY AND CONSTRUCTION AGENCIES
3. STATE AND TERRITORIAL MENTAL HEALTH AUTHORITIES

ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

NUMBER AND TITLE OF RECOMMENDATION:

STATEMENT OF RECOMMENDATION:

SUPPORTING STATEMENT:

A G E N D A

FEDERAL RELATIONS COMMITTEE

Chairman - Herman E. Hilleboe, M.D.	New York
Vice-Chairman - Roy L. Cleere, M.D.	Colorado

Members

R. B. Aiken, M.D.	Vermont
Albert E. Heustis, M.D.	Michigan
L. J. Peterson	Idaho
S. J. Phillips, M.D.	Louisiana
Mack I. Shanholtz, M.D.	Virginia
Felix J. Underwood, M.D.	Mississippi

Liaison

Dr. Jack C. Haldeman	Public Health Service
Dr. Arthur J. Lesser	Children's Bureau

Room 5051
HEW Building North
December 6, 1954

FEDERAL RELATIONS COMMITTEE

1. Birth Record Management and National Security

2. Cataloguing and Reappraisal of Existing Reports by State Health Departments to Federal Agencies

3. Change in the Allocation Formula Applied to Grants-in-Aid for Cancer Control Activities

4. Development of Patterns of State Legislation Applicable to Local Health Units

5. Grant-in-Aid Policies

6. M & CH Annual Reporting Requirements

7. Penalty Mail in Vital Statistics and Communicable Disease Reporting

8. PHS Compensation to States for Statistical Copies of Certificates of Birth, Death, and Fetal Deaths

9. Recruitment and Utilization of Inactive Reserve Corps for the Public Health Service

10. Restricted Areas Under Operation of Federal Government Involving Use of Radioactive Materials

11. School Health Services

12. Uniform Statistical Reports by Tuberculosis Hospitals

Submitted by: Subcommittee Chairman Federal Relations Committee

Recommendations on Birth Records and National Security
to the Federal Relations Committee of the ASTHO

Action desired:

ADOPTION OF RECOMMENDATIONS:

1. THAT THE "1951 MINIMUM STANDARDS RECOMMENDED FOR DELAYED BIRTH REGISTRATION," APPROVED BY THE PUBLIC HEALTH CONFERENCE ON RECORDS AND STATISTICS (DOC. NO. 284), BE ADOPTED AND APPLIED BY ALL REGISTRATION AREAS AT THE EARLIEST POSSIBLE DATE, AND THAT DELAYED REGISTRATIONS OF BIRTH OCCURRING IN THE UNITED STATES SHALL BE MADE ONLY IN THE STATE OF BIRTH.

2. THAT ANY CERTIFIED COPY OF A DELAYED BIRTH REGISTRATION INCLUDE THE DATE OF FILING, AND AN ABSTRACT OF THE SUPPORTING EVIDENCE, AND THAT THE WORD "DELAYED" APPEAR ON THE FACE OF THE COPY.

3. THAT A CERTIFICATION OF A RECORD AMENDED TO SHOW CHANGE OF NAME BY COURT ORDER MADE AFTER THE 15TH BIRTHDAY OF THE REGISTRANT SHALL SHOW THIS FACT OF AMENDMENT CLEARLY IN THE TEXT OR OTHERWISE BE CLEARLY INDICATED ON THE DOCUMENT, EXCEPT IN CASES OF ADOPTIONS AND PATERNITY DETERMINATIONS.

4. THAT ANY SHORT FORM CERTIFICATION SHALL INCLUDE THE NAME AND SEX OF THE REGISTRANT, DATE AND PLACE OF BIRTH, DATE OF REGISTRATION, DATE OF ISSUANCE AND CERTIFICATE NUMBER.

5. THAT THE STATES TAKE ALL STEPS POSSIBLE IN THE INTERESTS OF NATIONAL SECURITY TO PROTECT THE INTEGRITY OF VITAL RECORDS AND TO PROVIDE FOR THE PHYSICAL PROTECTION AND SAFEGUARDING OF VITAL RECORDS GENERALLY.

6. THAT THE DHEW ESTABLISH A CLOSE LIAISON WITH THE DEPARTMENTS THAT SUBMITTED THE RECOMMENDATIONS CONSIDERED BY THIS SUBCOMMITTEE IN ORDER TO EXPLORE THE FEASIBILITY OF ALLEVIATING THE PROBLEMS BY

A. IMPROVING THE UNDERSTANDING OF APPLICANTS FOR PASSPORTS;

B. REVIEWING PROCEDURES FOR DELIVERY OF INFORMATION FROM BIRTH RECORDS TO THE FEDERAL AGENCIES BY THE VITAL STATISTICS OFFICES, AND

C. CONSIDERATION OF OTHER RELATED MATTERS.

7. THAT THE ASTHO MAKE THE FOLLOWING RECOMMENDATION (EXCEPT FOR THE UNDERSCORED MATTER THIS RECOMMENDATION WAS ADOPTED IN THIS SAME FORM BY THE ASSOCIATION ON DECEMBER 11, 1952):

THAT THE EXECUTIVE OFFICE OF THE PRESIDENT OF THE UNITED STATES STUDY THE CURRENT PRACTICES AND PROBLEMS OF VARIOUS FEDERAL AGENCIES RELATIVE TO THE RECORDING OF BIRTHS, DEATHS, MARRIAGES AND DIVORCES OF UNITED STATES CITIZENS OUTSIDE OF THE JURISDICTION OF THE UNITED STATES, INCLUDING BIRTHS OF FOREIGN-BORN PERSONS WHOSE STATUS HAS CHANGED BECAUSE OF ADOPTION OR LEGITIMATION BY UNITED STATES CITIZENS, WITH A VIEW TOWARD THE ENACTMENT OF FEDERAL LEGISLATION WHICH WOULD MAKE ONE FEDERAL AGENCY RESPONSIBLE FOR THE ADMINISTRATION OF AN ORDERLY AUTHENTIC SYSTEM OF VITAL REGISTRATION. IT IS FURTHER RECOMMENDED THAT THIS PROBLEM BE BROUGHT TO THE ATTENTION OF THE WORLD HEALTH ORGANIZATION.

Supporting Statement:

(Numbered to correspond with recommendation to which they refer.)

1. The Public Health Conference on Records and Statistics approved Doc. No. 284 (see copy attached) in 1951 and re-affirmed its approval in 1954. These are minimum standards only and this recommendation is not intended to deter States from prescribing higher standards. Some 26 States have adopted these standards for delayed registration, but, in practice, enforcement and application of such standards vary. There is need for a more uniform application of these standards in the interests of national security. Delayed registrations based upon less than minimum standards do not protect the national security to the extent that they are open to establishment by persons not actually born in the United States.

It is a fundamental principle of registration procedure that the event should be registered only in the area in which it took place. The possibility of establishing a record in more than one State creates obvious confusion and facilitates the establishment of fraudulent records.

2. Since a delayed certificate is not prima facie evidence of the facts as is a birth registration established at the time of birth, it is pertinent that any agency concerned with the national security receiving such a copy be able to ascertain the fact that it is a delayed certificate. To facilitate the determination whether it is acceptable, it is important that the copy show an abstract of supporting evidence.

3. The agencies submitting the recommendation justly feel that essential information may be concealed in the situation where there has been a change of name by court order and there is no indication on the copy of the certificate showing that fact. The original recommendation of the Federal agencies proposed that the copy of <u>any</u> amended record be plainly labelled. However, the Subcommittee felt that except in the specified situation of the change of name, corrections made under State statutes did not appear to

create an obstacle to the enforcement of security rules. The Subcommittee also felt legal change of name of individuals under the age of 15 did not represent a problem, and that adoptions and paternity determinations only remotely presented problem situations.

4. The recommendation by the agencies was to include "sufficient information to appropriately identify the holder." The recommendation has been restated to eliminate these words since it is impossible for vital statistics offices to comply. The items in the Subcommittee recommendation are desirable and represent the minimum necessary to enable any agency to reach a conclusion regarding the value of certification.

5. It has to be recognized that there are practices in many States which allow the misuse of records and while the Subcommittee realizes that their correction is extremely difficult, on the other hand the Subcommittee feels that it cannot ignore this fact. Accordingly, it makes the above recommendation in general terms only. It appears impractical to try to establish uniform practices of such specificity as to preclude every possibility of misuse. But any step which would make such misuse more difficult would be of value. It is apparent that safeguarding of the records by improved physical facilities will minimize the opportunity for tampering with the records.

6. In the discussion of the recommendations of the Federal agencies it became evident that there are difficulties in the relationships between the States and the Federal agencies. Since there seem to be certain points in which this inter-relationship must be clarified and made more workable the logical agency to establish this relationship on a firmer basis is the counterpart of the State agency in the Federal Government, namely, the DHEW. National security in these matters is completely dependent on full cooperation of all agencies involved. It was noted in the discussion that some of the difficulty experienced by the Department of State may be the result of inadequate understanding on the part of the applicants for passports of the type of certified copies of birth certificates required. In this area, for example, negotiations conducted as recommended may well result in improved working relationships between the State and Federal agencies and give rise to modifications of procedures of both State and Federal agencies to better serve national security interests.

7. In view of the developments along national security lines and the recommendations submitted by the Federal agencies, the recommendation of the ASTHO seems to be even more a propos now than when originally made. Some of the State practices which seem to cause difficulty for the Federal agencies could be eliminated if the Federal Government were to offer the recommended service. One of these practices is to file birth certificates for foreign-born children adopted by United States citizens. State legislatures have enacted laws to this effect, which are contrary to a sound system of registration and which create hazards to the national security by implying

such persons were born in the United States and/or are United States citizens. A Federal system of registration should cover such situations and pressures on the States for such legislation would thereby be eliminated.

NOTE: In regard to the recommendation of the Federal agencies (see Background Statement, October 19, 1954, attached), "That pertinent birth facts....be made available upon request to the....security agencies of the Federal Government," the Subcommittee does not feel the recommendation is practicable at this time. State procedures now in effect permit authorized persons to obtain necessary information for investigative and enforcement purposes. Until further evidence is presented that there is a real problem, no change is recommended. In any event legislation deemed necessary for the solution of the problem should be initiated from sources other than the ASTHO.

APPENDIX A
DOCUMENT NO. 284 - 8/28/53
(Replacing Doc. No. 156)

1951 MINIMUM STANDARDS RECOMMENDED FOR DELAYED BIRTH REGISTRATION

as Approved by the
Public Health Conference on Records and Statistics

Reproduced by

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
National Office of Vital Statistics

August 1953

1951 MINIMUM STANDARDS RECOMMENDED FOR DELAYED BIRTH REGISTRATION

I. Procedure for Registration

A. Definition

"Delayed Registration of Birth" means the registration of a person's non-recorded birth on or after his fourth birthday. (It is recognized that States may, by law or regulation, establish a lower critical age.)

B. Requirements for establishing the facts of birth

1. Facts to be Established.--In all instances of delayed registration of birth, all of the following facts concerning the person whose birth is to be registered must be established:

   (a) Date of birth;
   (b) Place of birth; and
   (c) Parentage

2. How Facts may be Established.

   (a) If the person whose birth is to be recorded be a child under 12 years of age; the facts of birth entered on the certificate shall be supported by at least one piece of documentary evidence.

   (b) If the person whose birth is to be recorded be 12 years of age or over:

      i. Date of birth and place of birth shall be supported by at least three documents, of which only one may be an affidavit.
      ii. Facts of parentage must be supported by at least one document which may be one of the three submitted as evidence of the other facts.

Documents, other than the supporting affidavit, shall be at least five years old or shall have been made from records established at least five years prior to the date of application.

The types of documentary evidence which may be accepted to establish the fact of American birth are shown in Part II.

I. Procedure for Registration -- Continued

C. Responsibility for investigation of cases

The responsibility for determining when documentary evidence submitted is sufficient to warrant the issuance of a delayed certificate of birth belongs to the State Registrar of Vital Statistics.

D. Oath of the Registrant

1. If the person whose birth is to be recorded be of legal age, the certificate shall be signed by the registrant, if possible; otherwise by his duly authorized representative.

2. If the person whose birth is to be recorded be a child under legal age, the birth certificate shall be signed by the attendant at birth (physician or midwife). If the attendant at birth is dead or cannot be located, the certificate shall be signed by a parent or guardian.

This signature links the identification of the person to the certificate. Each person signing a certificate shall attest under oath to his belief in the truth of the statements made concerning the age, birthplace, and parentage of the person whose birth is being recorded.

E. Certification by reviewing official

The responsible registration official, or his designated representative, should certify:

1. That no prior birth certificate is on file for the person whose birth is to be recorded.

2. That he has reviewed the evidence submitted to establish the facts of birth; and

3. That the summary, or abstract thereof, appearing on the delayed certificate conforms to the statements as set forth in the evidence.

When the registration of the delayed certificate is subject to court order, the official of the court should make the above certification; and the responsible registration official should then certify to the fact that he has received and signed the certificate.

F. Form of Delayed Certificate of Birth

The form of the delayed certificate of birth as set out in Part III embodies the minimum requirements.

II. Evidence Required to Prove American Birth

The types of evidence which are acceptable to establish the facts necessary to file a delayed certificate of birth are set forth below in the order of preference.

When a document less than five years old or which was made from a document established less than five years prior to the date of application is submitted to establish the birth facts, other than the supporting affidavit, such document shall not be considered as acceptable evidence; but should be studied by the examining officer in his review of the case.

A. Types of Documents considered to be Acceptable Evidence

As a general rule, written documents made or established at or near the time of birth are considered the most desirable.

Hospital record

A photostat copy or abstract from the record certified by the person having custody of the hospital records should be required.

Physician's record

A photostat copy or abstract from the office record of the physician who attended the birth should be submitted. This should be certified to by that physician.

Record from a local, State, or Federal Census

The value of these records as evidence will vary depending upon the date and circumstances under which made. When the applicant can submit two consecutive decennial Federal census records, these documents should be accorded great weight in evidence.

Family Bible record

Bible records should be accorded weight in evidence only when it can be proved beyond reasonable doubt that the entry was made prior to the fourth birthday of the applicant. In the event that the Bible itself cannot be submitted, a photostat copy of the pertinent facts should be required or a sworn affidavit statement. In all cases, the date the Bible was printed, the name and address of the present custodian of the Bible should be required of the person submitting the document.

II. Evidence Required to Prove American Birth -- Continued

Church records, such as Baptismal, Cradle Roll, Confirmation, et al.

When a person is a member of a particular religious group and was baptised, christened, or otherwise accepted in the church during infancy or early childhood, in conformance with the normal requirements of the religion concerned, either the certificate given the person at the time of the event or an official signed statement from the present custodian of the church records should be required.

School records

A photostat copy or abstract certified to by the person having custody of the official school records should be required. This statement should be obtained from the earliest date of attendance for which the party can secure such record.

Insurance policy application

Either the insurance policy application blank or an abstract statement certified to by the custodian of this insurance company's records should be submitted.

Armed Forces Service Discharge papers

Official discharge papers of the Army, Navy, Air Force, Coast Guard, et al., may be submitted.

Social Security Application blanks

An abstract from the social security application blank signed by a proper custodian of the records may be submitted.

Other types of Documents

There are many other documents which may prove acceptable in evidence. Such factors as age and the circumstances under which made will determine their acceptability. Each such document submitted should be examined carefully because its value in evidence is less than that of documents listed above:

Driver's license
This may include: automobile, aircraft, boat.

Marriage record
A certified copy of the marriage certificate, license, or application should be submitted, whichever supplies the required facts.

II. Evidence Required to Prove American Birth -- Continued

Other types of Documents

Voting registration record

Employment record
This should be a photostat or abstract from the official records of the company where employed and be signed by the Officer in whose custody they are kept.

Birth certificate of registrant's child
A certified copy should be submitted, if not in possession of the registrar to whom application is made for the delayed registration.

Record from an organization-
Of which applicant is, or at one time was a member, whether trade, professional, social, or fraternal.

Newspaper clipping
When a clipping or abstract from a recognized newspaper, whose archives are accessible, is presented, this may be accepted, provided that the name of the paper, the location of its archives, and the page number and date of issue are given. A photostat or certified abstract of the item by the custodian of the archives is preferred.

Affidavits

The value of the affidavit submitted to establish the birth facts on a delayed certificate of birth should be weighed carefully.

1. The affidavit of a reliable physician who attended the birth should be given considerable weight if he states that there is an office record of the event.

2. In every case where an affidavit is used to establish the birth date, the affiant should state why he knows and remembers the date.

3. In every case, the relationship of the affiant to the registrant should be stated.

II. Evidence Required to Prove American Birth -- Continued

B Minimum requirements for documents

To be accepted as evidence of the birth facts of an individual, any documents submitted must contain, in addition to the name of the person, one or more of the following facts:

1. Date of birth or age
2. Place of birth
3 Name of father
4. Maiden name of mother

Any document submitted must further contain all of the following information if it is to be acceptable in evidence:

1. The official name of the agency or organization which has custody of the original record, if any;
2. The date the record was made;
3. The place the record was made;
4. The person now having custody of the record;
5. If a copy of a record is submitted, the date the copy was made and the person who made the copy.

C Abstracting Supporting Evidence.

The person abstracting the evidence on the delayed certificate of birth should carefully check any abstract notations to determine whether the following facts can be ascertained from such notes:

1 Is the document abstracted clearly identified and its location stated: For example: if a baptismal record is submitted what church has the record. Where is the church located. When was the record made. Who issued the copy. On what date was the copy made. If a marriage record is submitted, what county and state has the record. When was the record filed. Who issued the copy. What date was the copy made.

2. Are all birth facts given on the document listed exactly as given on the document. Where no data is given for a particular item, was the notation "none stated" entered.

III. Form Recommended.

The following form is the recommended certificate for delayed registration. (It has been "boxed" to conform with the other types of recommended forms.)

IMPORTANT! This is a Permanent Record. Use Typewriter or Ink.

COLUMBIA STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH STATISTICS

DELAYED CERTIFICATE OF BIRTH

Certificate Number

REGISTRANT (Person whose Birth is being registered)	1. Registrant's Full Name at Birth			2. Month Day Year — BIRTH DATE
	3. Color or Race	4. Sex	5a. City or town of birth — BIRTH PLACE	5b. County of birth
FATHER	6. Full Name of Father			7. State or country of Father's birth
MOTHER	8. Full Maiden Name of Mother			9. State or country of Mother's birth
AFFIDAVIT	I hereby declare upon oath that the above statements are true to the best of my knowledge and belief.		10. Signature of Registrant	11. Present address of Registrant
NOTARY (Seal)	Subscribed and sworn to before me on 19		12. Signature of Notary	13. Notary Commission expires 19

APPLICANT — DO NOT WRITE BELOW THIS LINE

Type of Document		By whom issued and signed	Date Issued	Date Orig. Entry
Date of Birth	Birth Place	Full Name of Mother	Name of Father	
Type of Document		By whom issued and signed	Date Issued	Date Orig. Entry
Date of Birth	Birth Place	Full Name of Mother	Name of Father	
Type of Document		By whom issued and signed	Date Issued	Date Orig. Entry
Date of Birth	Birth Place	Full Name of Mother	Name of Father	
Type of Document		By whom issued and signed	Date Issued	Date Orig. Entry
Date of Birth	Birth Place	Full Name of Mother	Name of Father	

QUALIFYING INFORMATION

REGISTRAR'S CERTIFICATION (Seal)

I hereby certify that no prior birth certificate has been found in the Division of Public Health Statistics for this registrant and that documentary evidence has been reviewed, which substantiates the facts as set forth in the foregoing abstract.

State Registrar	Evidence reviewed by	Date Filed

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
Public Health Service
National Office of Vital Statistics
Washington 25, D. C.

October 19, 1954

BIRTH RECORD MANAGEMENT AND NATIONAL SECURITY

Background Statement

For Administrative Use by Members of the
Association of State and Territorial Health Officers,
Public Health Conference on Records and Statistics,
and
American Association of Registration Executives

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Reference

The Confidential Nature of Birth Records
(Children's Bureau Publication No. 332-1949)

Birth Record Management and National Security--10/19/54

The Proposals of Federal Agencies

The Federal agencies concerned with the problem have proposed that the following practices be adopted as minimum requirement throughout the vital registration system:

(1) That all birth certificates issued on delayed birth records be clearly indicated as such;

(2) That all certificates issued on amended birth reports be plainly labeled;

(3) That birth registration cards issued include sufficient information to appropriately identify the holder, including his name, date and place of birth, the registration and certificate dates and numbers;

(4) That pertinent birth facts, including facts on adoption cases, be made available upon request to the State Department, Immigration and Naturalization Service, and the security agencies of the Federal Government;

(5) That uniform standards relating to the creation of delayed birth registers be enacted;

(6) That regulations be issued by the States to preclude access to birth records by unauthorized persons.

Purpose of the Proposals

False birth certificates or genuine birth certificates in the hands of impostors have been used to:

(1) Obtain passports permitting entry into the United States, or permitting travel abroad under the guise of U. S. citizenship; and to

(2) Enter the United States at the Mexican or Canadian borders, by masquerading as U. S. citizens returning from our neighbor countries.

In addition, short form birth certificates, or those issued from amended birth records may conceal the fact of birth in a foreign country or other facts that would give another country a claim on the registrant. Such persons, having "dual citizenship" may be subjected to military service, or other restrictions, if they visit the foreign countries whose laws claim their obedience.

The recommended birth record practices would serve to assist the Federal Departments concerned in preventing these illegal acts and unfortunate occurrences.

Joint Statements of Federal Departments Concerned

The following statements have been made by representatives of Federal Departments in discussing these problems:

"The illegal entry of persons by means of false and misleading statements or by presentation of false or forged documents is a serious problem confronting the Immigration and Naturalization Service. Considerable numbers of aliens have effected or attempted to effect illegal entries into the United States by procuring false birth certificates showing birth in the United States and thereafter entering the United States masquerading as United States citizens. Also, a considerable number of aliens have entered or attempted to enter the United States through regular ports of entry by concealing facts which would make them excludable from the United States, specifically facts of membership in subversive organizations."

"The prevention of aliens from entering the United States either by obtaining United States passports by fraud or by obtaining visas upon the presentation of false evidence of birth in foreign countries, particularly countries in the Western Hemisphere, is a joint problem of the Department of State and the Immigration and Naturalization Service. It is a known fact that for many years Chinese have entered or attempted to enter the United States as United States citizens on documents obtained from the State Department by the presentation of false or fraudulent evidence of birth in the United States. Similarly a number of natives of other countries, particularly countries in the Western Hemisphere, have entered the United States or attempted to enter the United States on the presentation of false certificates of birth in the United States."

"It is concluded that there is definite need for stricter and more uniform laws in the various States governing the issuance of birth certificates. It is known that in many States the issuance of a birth certificate is more or less a formality and that it is comparatively easy for a person to obtain a birth certificate other than his own and thereafter put it to fraudulent use in assisting an alien in entering the United States."

False or Fraudulent Birth Certificates

From newspaper reports, court decisions, reports of registrars, and other sources, birth records are known to have been misused or falsified in the following ways.

All of these methods may create records useful to subversives, or others illegally entering the United States, as well as for other improper purposes, ranging from proof of drinking age, to fraudulently claiming inheritances.

1. Theft of forms and forging of records. In at least one city, blank certified copy forms were stolen, apparently to be sold to persons who might fill them in to suit their needs.

2. Alteration of genuine certified copies. Various cases have been reported in which genuine certified copies have been altered, sometimes skillfully and more often crudely, to support false claims.

3. Forging forms and records. Various forgeries of the forms themselves (including the old Census Notification of Birth Registration) have been reported.

4. Genuine filing of false certificates

a. Regular certificates of birth. Far-sighted Orientals are credited with instigating the filing of certificates of births that never occurred, in order to provide ready-made citizenship for persons entering the United States illegally many years later. Much more common are the cases in which birth out of wedlock is obscured by false statements of parentage.

b. False delayed registrations. Delayed registration of birth, falsely asserting age, parentage and birth place have been established by both judicial and administrative proceedings.

c. Falsification of registration following adoption. Birth out of wedlock, identities of the natural parents, and place (including foreign countries) and date of birth have been wilfully concealed by profession of ignorance of these facts on the part of adoptive parents or their agents, when applying for the establishment of new or supplemental records of birth following adoption.

5. Alteration of the original record. It is reported that at least one original record in the files of a vital statistics office was illegally altered so that a genuine certified copy, routinely requested later, displayed false information.

6. Use of genuine records by impostors. Genuine records are obtained by numerous methods for the use of impostors. They may be stolen or purchased from their true owners. Sufficient information to

enable the impostors to obtain them directly from the vital statistics offices may be obtained from the true registrants, their families, friends, employers, or from organizations in which they belong, from press accounts of their births (or deaths), from biographical sketches published in numerous ways, or in visits to local vital statistics offices to search the records.

The Recommended Practices Today

The record management practices recommended by Federal Departments concerned cannot absolutely prevent any of the fraudulent acts mentioned above. However, it is believed that general adoption of the recommended practices would tend to reduce the number of fraudulent claims of citizenship.

Nationwide adoption of the recommended practices would require some legislation in most States, and certain administrative actions in all States.

In the following pages, the present situation with respect to each recommendation is summarized.

Recommendation I: THAT ALL BIRTH CERTIFICATES ISSUED ON DELAYED BIRTH RECORDS BE CLEARLY INDICATED AS SUCH.

Recommendation V: THAT UNIFORM STANDARDS RELATING TO THE CREATION OF DELAYED BIRTH REGISTERS BE ENACTED.

Present minimum standards for delayed birth registration were adopted in 1941, after three years of joint studies by State and Federal officials. Yet as late as 1951, between 13 and 19 State offices still did not set forth the word "Delayed" on certified copies issued from delayed birth records. Some State offices which do enter the word "Delayed" on full certified copies, do not enter the word on short form certifications.

Virtually all State offices enter the "date of filing" on copies issued from birth records. Some believe that persons reviewing these copies should be able to ascertain that they are "delayed" from the date of filing.

Review of current delayed registration practices discloses that there is widespread variation between State practices.

1. While virtually all State vital statistics offices process delayed birth registration applications, in over 20 States the courts exercise a concurrent jurisdiction.

2. In some States, residents may file a delayed birth registration, even though born in another State.

3. The processing of delayed registration applications is carried on at the local level in many States, with the State office function limited to review of the case.

4. Many State offices contend that they can neither establish or maintain the minimum evidentiary requirements recommended for delayed registration because large segments of their population are unable to submit the documentary proofs prescribed. In some instances, States that have attempted to strengthen these standards have encountered political opposition.

5. While the overwhelming majority of States have laws governing delayed registration, there are still States with no statute law on the subject.

Recommendation II: THAT ALL CERTIFICATES ISSUED ON AMENDED BIRTH REPORTS BE PLAINLY LABELED.

There are a number of reasons why some birth certificates must be amended, supplemented, or even replaced. For example, a given name may have been omitted from the original certificate. Information may have been entered incorrectly. The individual may have undergone a legal change of name. An individual may have undergone a change in civil status through adoption or legitimation.

Virtually all States prescribe in law or regulation procedures for the amendment or alteration of birth records. In the vast majority of cases, precautions are taken to acquaint the user of vital records with the fact of amendment or alteration. As a matter of public policy, however, the law of many States has taken extraordinary precautions to prevent the inadvertent or indiscriminate disclosure of the fact of change in civil status following adoption or legitimation. This is done to protect the person from personal distress or hardship which might arise from needless disclosure of these facts.

In every case, however, the law permits disclosure of all matters recorded to persons with a direct, legitimate interest, upon demand of the individual, if of age, or at least upon court order.

Recommendation III. THAT BIRTH REGISTRATION CARDS ISSUED INCLUDE SUFFICIENT INFORMATION TO APPROPRIATELY IDENTIFY THE HOLDER, INCLUDING HIS NAME, DATE AND PLACE OF BIRTH, THE REGISTRATION AND CERTIFICATE DATES AND NUMBERS.

Birth cards and other short forms of birth record abstracts and certifications are used most commonly as evidence of age--to establish eligibility to take a job, buy liquor, apply for a driver's license, etc. The full certified copy is generally requested where parentage, place of birth or citizenship are in question.

It is probable that the short form certificates now in circulation greatly outnumber the full certified copies. Many of the birth cards now being issued do not show the date of filing of the record from which they are abstracted or any other information that would distinguish between original records routinely filed, or those that were delayed, corrected or amended.

Recommendation IV. THAT PERTINENT BIRTH FACTS, INCLUDING FACTS ON ADOPTION CASES, BE MADE AVAILABLE UPON REQUEST TO THE STATE DEPARTMENT, IMMIGRATION AND NATURALIZATION SERVICE, AND THE SECURITY AGENCIES OF THE FEDERAL GOVERNMENT.

It has been noted above that State laws generally prohibit disclosure of certain types of birth record information (viz. birth out of wedlock) and in some cases severely restrict access to all birth records. On the other hand, most States have general laws requiring all their officials to assist law enforcement officers where they can do so.

By liberal reading of these laws, many custodians of vital records now informally grant access to restricted birth record information to law enforcement officers, of State and Federal agencies.

Formal disclosures of "sealed" information to enforcement or investigative officers, in most States, can be made only upon the order of a court.

To our knowledge, no citizen has challenged such actions in the courts, however, and there is no clear assurance that the practice can be followed universally, or supported by regulations without legislative action.

In some offices, the increasing number of visits by law enforcement officers is becoming, or has become a burden, interfering with the regular service of the vital statistics office.

Recommendation VI. THAT REGULATIONS BE ISSUED BY THE STATES TO PRECLUDE ACCESS TO BIRTH RECORDS BY UNAUTHORIZED PERSONS.

Birth records often contain data whose release might prove damaging to the individual. For examples, the facts of birth out of wedlock, birth in certain types of institutions, and certain kinds of congenital malformations may prove embarrassing if indiscriminately revealed.

In addition, many individuals object to receiving direct mail advertising addressed from birth lists, or to any disclosure of the facts of their own births (or those of their children) to curiosity seekers.

Fear of such disclosures is suspected of leading to misstatements in the filing of records, and therefore, of reducing the value of the record as legal evidence and as statistical source material.

On the other hand, there has been in recent years an increasing demand for access to the records. Such demands may come from attorneys in general practice, title searchers, writers, professional genealogists, fraternal and patriotic societies, mailing list compilers, and the press. For these groups, the access desired may consist of freedom to purchase full certified copies of individual records, opportunity to inspect specified records, freedom to examine any and all records on file, or merely the opportunity to obtain lists of births regularly.

The result of these conflicting interests is a considerable degree of variance in State laws. Most essay to permit access only to those able to demonstrate direct, tangible interest in the record. Others make all birth records public, requiring concealment only of the facts of birth out of wedlock, and the particulars of natural birth after adoption has occurred.

In addition to this wide variation in statutory principle from State to State, there often are differences within individual States between the controls applied at local and State levels.

Furthermore, the laws generally allow a degree of discretion to the custodians of the records at State and local levels.

In most States any effort to change the existing conditions of law and administration on access to birth records is likely to arouse controversy. It should be noted also that each step toward further restriction of access increases the cost of birth record management, and reduces the speed of service to the general public.

Submitted by: New York Department of Health
Oregon Board of Health

Federal Relations
Committee

Cataloguing and Reappraisal of Existing Reports by State Health Departments to Federal Agencies

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE MEMBERSHIP AND RESPONSIBILITIES OF THE JOINT COMMITTEE ON PHS-CB RECORDS AND REPORTS BE EXPANDED OR THAT A NEW COMMITTEE BE ESTABLISHED TO RE-EXAMINE PRINCIPLES, VALUE AND USE OF THE REPORTS WHICH THE FEDERAL AGENCIES SHOULD RECEIVE FROM STATE HEALTH DEPARTMENTS. THIS COMMITTEE SHOULD PLAN TO CONSIDER THE ENTIRE REPORTING STRUCTURE, PROGRAM BY PROGRAM, INCLUDING THE NEEDS OF BOTH THE PUBLIC HEALTH SERVICE AND THE CHILDREN's BUREAU, AS WELL AS THE VALUE THE COLLECTION AND ANALYSIS OF SUCH MATERIAL HAS FOR THE INDIVIDUAL STATE.

THAT, AS AN INTIAL STEP, THE PUBLIC HEALTH SERVICE AND CHILDREN'S BUREAU PREPARE A MANUAL ON APPROVED RECORDS AND REPORTS.

Supporting statement:

For several years there has been a joint committee of the Public Health Service, Children's Bureau, and Association of State and Territorial Health Officers to consider changes in existing reports which State health agencies submit to the Federal Government. The work of this committee has indicated that there is need for a complete resurvey of the entire problem, rather than limiting its activities to changes in the existing system which are deemed desirable by the Federal agencies.

Many record and report forms have been developed and approved, but, to our knowledge, there is no index or manual available to State and Territorial health departments which contains a complete listing of approved records and report forms. It would be most helpful to these departments and to the joint committee to have such a manual. In addition, it would seem that such a manual would serve as a useful administrative tool for the Public Health Service and Children's Bureau.

Submitted by: Public Health Service

Federal Relations Committee

Change in the Allocation Formula Applied to Grants-in-aid for Cancer Control Activities.

Action desired:

ADOPTION OF RECOMMENDATION:

THAT GRANT-IN-AID FUNDS AVAILABLE FOR CANCER CONTROL ACTIVITIES BE ALLOCATED ON THE BASIS OF THE EXISTING FORMULA EXCEPT THAT, ALLOCATIONS BE ADJUSTED SO THAT NO STATE WILL RECEIVE LESS THAN $15,000. THE NECESSARY FUNDS FOR THESE ADJUSTMENTS WILL BE ACQUIRED BY PROPORTIONAL REDUCTIONS IN THE GRANTS TO THE OTHER STATES.

Supporting statement:

Under the application of the existing formula based upon population, financial need as measured by per capita income and the extent of the cancer problem as measured by cancer mortality and the sparsity of population, certain States receive allocations that are too small to permit them to establish the basic elements of a cancer control program. The minimum suggested will provide funds sufficient to employ a full-time program director, clerical employees, and some operating funds in each State. While no change in the regulations are necessary to adopt this change in formula it seems advisable to inform the State and Territorial Health Officers of the contemplated change so that we may have their reaction to it.

The concept of a minimum grant has been used in the mental health program from the beginning so this change is not without precedent in the field of grants-in-aid for public health.

Submitted by: Public Health Service

Federal Relations Committee

Development of patterns of State legislation applicable to local health units, including proposed model legislative language which may be used by the States

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATE AND TERRITORIAL HEALTH OFFICERS APPOINT A COMMITTEE TO WORK WITH THE PUBLIC HEALTH SERVICE IN DEVELOPING PATTERNS OF STATE LEGISLATION APPLICABLE TO LOCAL HEALTH UNITS, SUCH WORK POSSIBLY TO INCLUDE MODEL LEGISLATIVE LANGUAGE WHICH MAY BE USED BY THE STATES.

Supporting statement:

The Public Health Service made a study of State laws applicable to local health units about two years ago. This study summarized existing provisions of State law in regard to the following phases of local health legislation:

a. Authority for establishing local health units.
b. Powers and duties of boards of health, health officers, and health departments.
c. Appointment and composition and qualifications of boards of health.
d. Appointment and qualifications of health officers.
e. Financing of local health departments.
f. Staffing of local health departments.

The committee may find it helpful to base its consideration on the above study in the development of patterns of State legislation applicable to the above phases of local health administration. Perhaps the committee will wish to propose model legislation with respect to at least some of the proposals.

Proposed patterns of legislation or model legislative language are badly needed and frequently requested by States about to engage in a legislative program with respect to local health services.

It is suggested that the committee which is appointed include representatives of State health officers, local health officers, State directors of local services, American Public Health Association, and directors of administrative services in State health departments.

Submitted by: California Department of Public Health

Federal Relations Committee

Grant-in-Aid Policies

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS SET FORTH A REVISED POLICY ON FEDERAL GRANTS-IN-AID FOR HEALTH BASED ON: (1) A RE-EXAMINATION OF ITS POLICY STATEMENT OF 1953 THAT "FEDERAL GRANTS-IN-AID FOR HEALTH SHOULD CONTINUE AS AN ESSENTIAL FORM OF FEDERAL-STATE PARTNERSHIP AS A MUTUAL RESPONSIBILITY IN THE PROTECTION OF THE HEALTH OF ALL THE PEOPLE," (2) CONVERSATIONS BETWEEN THE EXECUTIVE COMMITTEE OF THE ASSOCIATION AND THE SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, (3) FINDINGS AND RECOMMENDATIONS OF THE KESTNBAUM COMMISSION ON INTER-GOVERNMENTAL RELATIONS, (4) FINDINGS AND RECOMMENDATIONS OF THE HOOVER COMMISSION ON ORGANIZATION OF THE EXECUTIVE BRANCH OF THE GOVERNMENT, AND (5) RECOMMENDATIONS OF THE SUB-COMMITTEE ON GRANTS-IN-AID OF THE FEDERAL RELATIONS COMMITTEE.

THAT THE ASSOCIATION RECOGNIZE THE PRINCIPLES: (1) THAT SUCH FEDERAL FINANCIAL ASSISTANCE SHOULD INCLUDE IN ITS AIMS THE DEVELOPMENT OF PROGRAMS TO MEET MAJOR, NEW HEALTH PROBLEMS IN THE STATES; AND (2) THAT, TO BE EFFECTIVE, THIS ASSISTANCE MUST BE MAINTAINED AT AN ADEQUATE LEVEL OF SEVERAL YEARS.

Supporting statement:

In recent years there has been a steady decline in Federal grants to the States for public health work. Beginning with 1953-1954 this cut has most sharply affected new programs such as cancer and heart disease control. Traditionally, the Federal Government has aided new endeavors in the special health field over several years, sufficient for them to become established in the States. Results of this policy are evident in the success of tuberculosis and venereal disease control efforts. The one-third cut in cancer and heart disease grants to the States (1953-1954 and 1954-1955, as compared with prior years) has seriously jeopardized important developing programs. The proposal to abandon these grants completely at this time has tended to undermine the establishment of a preventive, public health approach to cancer and heart disease, similar to that which has proved so useful in the case of other diseases.

Cancer and heart disease have become important health problems in the United States. Epidemiologic, case-finding, health education, and other public health measures are now being developed to cope with them. Federal assistance to States would hasten the perfection and application of techniques to control these diseases. Assistance for these specific purposes would maintain the traditional Federal-State collaboration for improvement of the public health.

Submitted by: New Jersey Department of Health

Federal Relations Committee

Maternal and Child Health Committee

M.C.H. Annual Reporting Requirements

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. CHILDREN'S BUREAU SIMPLIFY THEIR REPORTING DEMANDS UPON THE SEVERAL STATE MATERNAL AND CHILD HEALTH PROGRAMS TO A COMPARATIVE LEVEL ACHIEVED IN THE CRIPPLED CHILDREN PROGRAM FEDERAL REPORTING.

Supporting statement:

In designing new suggested annual reporting content, the Children's Bureau has assumed that each State has similarly established adequate local and county health departments from whom accurate program activity data can be obtained and collated at the State level. In some States, as in New Jersey, such county and local health departments do not exist. Therefore, federal reporting demands are unrealistic and data necessarily incomplete, resulting in a misleading Maternal and Child Health Program picture. Simplified reporting demands would result in greater comparability between States.

Cross reference:

A recommendation on this item should be made to the Federal Relations Committee by the Maternal and Child Health Committee.

Submitted by: Public Health Service

Federal Relations Committee

Penalty Mail in Vital Statistics and Communicable Disease Reporting

Action desired:

ADOPTION OF RECOMMENDATION:

THAT ALL COLLABORATING EPIDEMIOLOGISTS AND SPECIAL AGENTS OF THE PUBLIC HEALTH SERVICE IN STATE HEALTH AGENCIES CAREFULLY EXAMINE THEIR USE OF PENALTY (PHS) ENVELOPES AND POSTAL CARDS TO

a. ASSURE COMPLIANCE WITH POSTAL LAWS AND REGULATIONS; AND

b. PREPARE FOR INSTALLATION OF PROCEDURES FOR COUNTING THE PENALTY COVERS ACTUALLY MAILED IN THEIR REGISTRATION AND REPORTING SYSTEMS.

Supporting statement:

1. Postal laws limit the use of the penalty label to transactions which are exclusively the business of the Federal Government. Reported infractions of these laws arise which indicate that continuous precautions should be exercised to preclude such violations from occurring.

2. Legislation passed last year requires Federal agencies to budget and pay the Post Office Department for penalty label mailings. Most DHEW mailings are paid for in advance when the envelopes and postal cards are acquired. Special Agent and Collaborating Epidemiologists mailings cannot accurately be paid for in this fashion. Many of the envelopes and postal cards for disease reports that are supplied to private physicians are never mailed. Likewise many of the reply envelopes furnished with queries mailed to complete or refine answers to statistical items on birth and death certificates are never returned.

An accounting procedure is needed, to prevent overpayment of postage for such items, by confining payment to those items that actually get postmarked.

Submitted by: American Association of Registration Executives
Public Health Service

Federal Relations
Committee

PHS Compensation to States for statistical copies of certificates of birth, death, and fetal death

Action desired:

APPROVAL OF JOINT PROPOSAL:

1. THAT COMPENSATION TO STATES FOR MICROFILMING AND PUNCHING CERTIFICATES OF BIRTH, DEATH, AND FETAL DEATH FOR THE PUBLIC HEALTH SERVICE BE EQUITABLY LINKED TO THE COST INCURRED IN THESE PROCESSES, AND EXPRESSED IN RATES PER RECORD FILMED OR PER 1,000 CARDS PUNCHED;

2. THAT THE RATE FOR MICROFILM COPIES BE FIXED AT 2.5 CENTS PER RECORD INCLUDING THE COST OF NEGATIVE AND POSITIVE 16 MM FILM, FOR SUCH COPIES DELIVERED TO THE PUBLIC HEALTH SERVICE BETWEEN JANUARY 1 AND JUNE 30, 1955;

3. THAT THIS AGREEMENT NEED DETER NO STATE OFFICE USING MICROFILM FROM

   a. UNSING FILM PROVIDED BY THE PUBLIC HEALTH SERVICE, AND ACCEPTING COMPENSATION OF 2.5 CENTS PER IMAGE LESS THE GOVERNMENT CONTRACT COST OF THE FILM, IN ORDER TO TAKE ADVANTAGE OF THE CONTRACT PRICE;

   b. SPECIFYING 16 MM FILM AT 15 TO 1 REDUCTION OR 35 MM FILM AT A LESSER REDUCTION ACCORDING TO ITS OWN NEED, WITHOUT LOSS IN NET COMPENSATION UNDER 2 ABOVE; NOR FROM

   c. ACCEPTING A LESSER COMPENSATION IF THAT OFFICE HAS DETERMINED THAT ITS COST ARE LOWER.

4. THAT THE PUBLIC HEALTH SERVICE AND SEVERAL STATE OFFICES JOIN IN STUDIES TO DERERMINE THE ELEMENTS OF COST THAT NEED TO BE CONSIDERED IN FIXING COMPENSATION FOR DATA COPYING CONTRACTS TO BE ESTABLISHED IN FISCAL YEAR 1956 AND THEREAFTER;

5. THAT THE PUBLIC HEALTH SERVICE BEFING AT ONCE TO EXPLORE WITH THE STATE OFFICES WAYS OF REDUCING THE COSTS OF COPYING BY LIBERALIZING THE SPECIFICATIONS FOR SUCH MATTERS AS ARRANGEMENT OF CERTIFICATES ON MICROFILM REELS, FILMING OF QUERIES, TIME SCHEDULES FOR FILMING, AND TIME SCHEDULES FOR ACCOUNTING AND PAYMENT.

Supporting statement:

In joint review of existing compensation practices, the Public Health Service and a committee of the American Association of Registration Executives have proposed the following tentative principles:

(1) The principle of equitable cost is recognized as the basis upon which payment should be made;

(2) To avoid insofar as possible the necessity for State routinely to make cost analyses, we will arrange States into a limited number of groups based upon types of handling they make of certificates;

(3) That at a later date, but to be effective for fiscal year 1956 contracts, each of those groups of States will be assigned a unit cost price that is determined to be fair on the basis of this study as outlined below;

(4) Any State will be free to make cost analyses as bases for fixing contract prices with National Office of Vital Statistics. In making these analyses the cost of providing the microfilm for National Office of Vital Statistics will be the criterion. This study will work out as closely as possible an agreement between the National Office of Vital Statistics and the States as to which items are compensable costs.

Submitted by: Public Health Service

Federal Relations Committee

Recruitment and Utilization of Inactive Reserve Corps for the Public Health Service

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATE AND TERRITORIAL HEALTH OFFICERS ENCOURAGE THE DEVELOPMENT OF THE PUBLIC HEALTH SERVICE INACTIVE RESERVE CORPS AND WILL WORK CLOSELY WITH THE PUBLIC HEALTH SERVICE IN ESTABLISHING AREAS OF RECRUITMENT AND TRAINING AND UTILIZATION OF THIS INACTIVE RESERVE CORPS.

Supporting statement:

An atomic attack on the continental United States or its possessions would place a tremendous demand on the medical and associated health resources of the United States. The survival of hundreds of thousands of people would depend on the capacity of the Nation's physicians, dentists, nurses, sanitary engineers, and associated professional personnel to meet the emergency needs existing over the critical period of hours and days following an attack.

To meet the demands of such an emergency, the Federal Civil Defense Administration is organizing a system of mutual aid and mobile support which is intended to utilize the total health resources of the country. One phase of this plan requires that there be created a pool of trained physicians, sanitary engineers, nurses, and associated professional health personnel, who can be immediately mobilized and selectively deployed where needed to reinforce State and local health forces.

The inactive Reserve Corps of the Public Health Service is an existing mechanism which can be used most effectively both for (1) recruiting and organizing the necessary pool of officers, with provision for their prompt mobilization and deployment to points wherever needed throughout the country, and (2) a continuing program whereby such personnel can receive training in the highly specialized and rapidly changing techniques for coping with expected emergency problems.

The training program will be conducted in collaboration with State and local officials, with the object of developing mobile teams having not only specialized technical competence but experience in meeting Federal-State-local administrative and liaison problems on an emergency basis. Training periods will generally be of one or two weeks duration and brief enough not to interfere with the officer's normal duties and employment.

Submitted by: Connecticut Department of Health

Federal Relations Committee

Restricted Areas Under Operation of Federal Government Involving Use of Radio-Active Materials

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS ENDORSE CLEARANCE OF STATE HEALTH DEPARTMENT PHYSICISTS IN ORDER TO OBTAIN INFORMATION REGARDING POSSIBLE HEALTH HAZARDS ASSOCIATED WITH THE USE OF RADIO-ACTIVE MATERIALS AND ALSO THEIR STORAGE AND DISPOSAL.

Supporting statement:

P clearance is given without too much delay or expense, (i.e. cost of Q clearance is $250 for each person). However, it is questionable whether the person with P clearance can get as complete information desired as he would with a Q clearance.

It would be desirable to have information as to new planned activities involving radio-active materials rather than delay notification after it is in operation.

Submitted by: New York Department of Health

Federal Relations Committee

Maternal and Child Health Committee

School Health Services

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE BE REQUESTED TO TAKE THE NECESSARY STEPS TO ESTABLISH COORDINATED FEDERAL LEADERSHIP FOR SCHOOL HEALTH SERVICES.

Supporting statement:

The intrinsic value of school health services has never been satisfactorily evaluated and there are serious doubts as to the worth of many of the types of school health services being carried on. Responsibility for such services is scattered among a variety of agencies on the local level and it would be helpful if there could be established a clear unitary leadership on the Federal level which could correlate information presently available and which would design and help to carry out evaluative studies in the field and give leadership to the school health program.

Cross reference:

This item should be considered both by the Federal Relations Committee and the Maternal and Child Health Committee for joint recommendation.

Submitted by: Public Health Service

Federal Relations Committee

Infectious Diseases Committee

Uniform Statistical Reports by Tuberculosis Hospitals

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS COOPERATE WITH THE PUBLIC HEALTH SERVICE, THE AMERICAN HOSPITAL ASSOCIATION, AND THE AMERICAN TRUDEAU SOCIETY IN THE DEVELOPMENT AND INSTALLATION IN TUBERCULOSIS HOSPITALS, OR IN TUBERCULOSIS HOSPITAL SYSTEMS, OF A STANDARDIZED PROCEDURE TO PROVIDE IMPORTANT OPERATING AND PATIENT INFORMATION NECESSARY TO THE INDIVIDUAL HOSPITAL'S SELF EVALUATION, AND TO PROVIDE FOR INTERCHANGE OF COMPARABLE HOSPITAL AND PATIENT MANAGEMENT DATA.

Supporting statement:

Most tuberculosis hospitals prepare annual or biennial reports of their operation. (In some instances these reports are issued under the auspices of the State Health Department. In some instances they are issued by the tuberculosis hospital.) An aggregation of these reports would provide useful information related to tuberculosis hospital operation, to the characteristics of the patients admitted, hospitalized, and discharged, and to the response of patients to hospital treatment. However, the various reports are sufficiently different in their manner of presenting the same information that aggregation of the data presented is not feasible. The Division of Special Health Services of the Bureau of State Services in the Public Health Service is undertaking the task of bringing about greater uniformity in the reports of tuberculosis hospitals and in the tuberculosis reports of health departments so that aggregation of comparable statistics will be available to these organizations. Success in this undertaking will provide essential information for the understanding of tuberculosis hospitalization practices and problems and for the observation of trends in practices, problems and characteristics of the patient population.

Because many tuberculosis hospitals are under the direct control of State and Territorial health officers, and because State and Territorial health officers exercise indirect but none the less real control over many of the hospitals not under their direct jurisdiction, adoption of this recommendation by the Association of State and Territorial Health Officers' will be of inestimable value to the success of this undertaking.

Cross reference:

A recommendation on this item should be made to the Federal Relations Committee by the Infectious Diseases Committee.

A G E N D A

ENVIRONMENTAL SANITATION COMMITTEE

Chairman - Wilson T. Sowder, M.D.	Florida
Vice-Chairman - G. J. Van Heuvelen	South Dakota

Members

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Bruce Underwood, M.D.	Kentucky

Liaison

Mr. Mark D. Hollis	Public Health Service

Room 5022
HEW Building South
December 6, 1954

ENVIRONMENTAL SANITATION COMMITTEE

1. Air Pollution by Ragweed Pollen
2. Approval of Building Plats by Official Health Agencies
3. Certification of Crabmeat
4. Certification of Interstate Milk Shippers
5. Dispersion and Duplication of Federal Activities in the Field of Water and Sewerage
6. Equipment Standards for Shellfish Sanitation
7. Garbage Feeding to Hogs and the Control of Trichinosis
8. Investigation and Evaluation of Possible Hazards to Health of the Newer Insecticides
9. Sanitation Problems in Vending Machine Inspections
10. Shellfish Sanitation Control
11. Standards for Air Pollution Control

Submitted by: New Jersey Department of Health

Environmental Sanitation Committee

Air Pollution by Ragweed Pollen

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. PUBLIC HEALTH SERVICE STUDY THE HEALTH ASPECTS OF RAGWEED GROWTH, THE RELATIONSHIP OF VARIOUS CONCENTRATIONS OF POLLEN IN THE AIR TO ALLERGIC REACTIONS OF SENSITIVE INDIVIDUALS, AND THE DEVELOPMENT OF SUITABLE INSTRUMENTS FOR COLLECTING SAMPLES OF POLLEN TO EVALUATE THE REDUCTION OF POLLEN DUE TO RAGWEED ELIMINATION.

Supporting statement:

Since the discovery of the herbicide 2, 4-D, a simple practical method for the control of ragweed is available. This weed is now controlled in many communities and there is strong evidence to indicate that hay fever sufferers are benefited.

It is important to know more than is now known about the concentrations to which people are exposed and which cause allergic reactions. The concentrations of pollen near the growth of ragweed during the latter part of August are extremely high while the concentrations of the pollen on top of a building in the center of a city are comparatively low. Instruments that are practical for use by health departments in quantitatively evaluating control work are needed.

Submitted by: Pennsylvania Department of Health
Maryland Department of Health

Environmental Sanitation Committee

Approval of Building Plats by Official Health Agencies

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS ADVOCATE THAT PRIOR TO THE RECORDING OF SUBDIVISION PLATS IN UNINCORPORATED AREAS THE OFFICIAL HEALTH AGENCY SHOULD HAVE THE AUTHORITY TO APPROVE OR DISAPPROVE THE PLAT AS SUITABLE FOR BUILDING PURPOSES FROM THE POINT OF VIEW OF PROTECTION OF THE PUBLIC HEALTH, OR TO SPECIFY CERTAIN CONDITIONS UNDER WHICH DEVELOPMENT OF THE AREA WOULD BE PERMITTED, ESPECIALLY WITH RESPECT TO PROVISIONS FOR DISPOSAL OF SANITARY SEWAGE.

Supporting statement:

The present lack of supervision by governmental agencies of the development of suburban and rural areas for building purposes has resulted in many unhealthful conditions. In many cases subdivisions are developed in swampy land or on steep slopes, which lack sufficient water supplies and provisions for household waste disposal, have inadequate size lots and are too close to industrial areas. In order to provide desirable living conditions and to prevent the formation of blighted and slum areas, the standards applying to this control program should be based upon accepted principles of healthful housing, including minimum requirements for lot size, character of terrain, availability and safety of water supply, adequacy of household waste disposal, and the proximity of industrial establishments, railroads, and excessive traffic. The problem of sanitary sewage disposal is especially troublesome when individual disposal systems such as septic tanks are employed in areas not adapted to their use and where it is more feasible to have a single collecting and disposal system for the entire development.

The administration of regulations pertaining to individual home sewage disposal systems has been marked by considerable discussion and controversy in regard to soil percolation tests. The correlation between tests made utilizing soil augur holes and tests obtained using the standard square test holes should be established. Recent studies made by the Public Health Service Sanitary Engineering Center should be reviewed to determine whether or not the data collected conclusively answer all the questions raised with respect to these two methods of soil testing.

Submitted by: Florida Board of Health

Environmental Sanitation Committee

Certification of Crabmeat

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE INSTIGATE A CRABMEAT CERTIFICATION PLAN AND DRAW UP A MANUAL OF PRACTICE SETTING THE STANDARDS OF SANITATION AS WELL AS BACTERIOLOGICAL STANDARDS FOR CRABMEAT.

Supporting statement:

At the present time it appears that there is more public health significance in crabmeat than there happens to be in shellfish due to the recent outbreaks of food poisoning attributed to crabmeat.

Submitted by: New Jersey Department of Health

Environmental Sanitation Committee

Certification of Interstate Milk Shippers

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. PUBLIC HEALTH SERVICE INCREASE THE STAFF ASSIGNED TO THEIR CERTIFICATION PROGRAM FOR INTERSTATE MILK SHIPMENTS.

Supporting statement:

There is feeling on the part of some States that the program of the U. S. Public Health Service is inadequately staffed to assure importing States that the surplus milk in the exporting States is of a Grade A quality. This lack of confidence causes them to make their own inspections and defeats the purpose of the Certification Program.

Submitted by: North Dakota Department of Health

Environmental Sanitation Committee

Dispersion and Duplication of Federal Activities in the Field of Water and Sewerage

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS RECOGNIZE OFFICIALLY ITS OPPOSITION TO THE UNDESIRABLE TREND TOWARDS DISPERSION AND DUPLICATION OF FEDERAL ACTIVITIES IN THE FIELD OF WATER AND SEWERAGE.

THAT THE ASSOCIATION DIRECT A COMMUNICATION IN ITS BEHALF TO THE SECRETARY OF COMMERCE, CALLING ATTENTION TO THE ABOVE AND URGING HIM IN THE INTEREST OF ECONOMY AND EFFICIENCY TO AVOID DUPLICATION OF THE WORK OF THE PUBLIC HEALTH SERVICE AND THE STATE HEALTH AGENCIES. THIS SHOULD BE ACCOMPLISHED BY DISCONTINUING THE ACTIVITIES OF THE DEPARTMENT OF COMMERCE IN THE COLLECTION OF WATER AND SEWERAGE DATA, AND BY RECOGNIZING THE COMPETENCY AND PRIMARY RESPONSIBILITIES OF THE UNITED STATES PUBLIC HEALTH SERVICE IN THIS AND OTHER LONG RANGE NATIONAL PLANNING ACTIVITIES FOR THESE MUNICIPAL FACILITIES WHICH ARE OF SUCH VITAL IMPORTANCE TO PUBLIC HEALTH.

Supporting statement:

The primary responsibility for dealing with municipalities and industries on matters relating to water and sewerage rests, of course, with the State Health Departments. Practically all States require submission of plans and specifications for approval prior to construction. The responsibility for review and approval of new and modifying construction work necessitates comprehensive and detailed knowledge by the State agency of future needs for water supply and treatment facilities, sewage treatment and disposal works, and water pollution control measures in individual communities and river basins, and also the significant interrelationships among various portions of watersheds. The professional competencies required to discharge these responsibilities under normal operating conditions are applicable and even more vitally needed under emergency conditions such as civil defense, mobilization or anti-depression periods. The public health significance of these sanitary engineering activities is recognized.

In connection with the national aspects of these problems, well established channels exist between the States and the U.S. Public Health Service. The Public Health Service has national responsibilities in connection with certification of water supplies for interstate carriers and development of basin water pollution control programs. A competent staff has been maintained to deal with these and related water, sewerage and other public sanitation problems. More than 20 years ago, at the request of the Conference of State Sanitary

Dispersion and Duplication of Federal Activities in the Field of Water and Sewerage - Continued

Engineers, the Public Health Service undertook an activity for collection, analysis and publication of data on existing water and sewerage systems and future needs. This inventory has been revised periodically and currently is being brought up to date in cooperation with the States and communities.

In view of the well-defined and properly related activities and channels between local, State and Federal agencies in the field of water and sewerage, the tendency to duplicate and otherwise cause confusion and inefficiency at the Federal level by dispersion of various responsibilities among government agencies, should be promptly discouraged and discontinued. There have been a number of instances in which, through administrative action or legislation, assignments of responsibility have been made without recognition of competencies required or of the close relationship to existing programs. Often these newly created or uniformed agencies conduct operations without due regard for responsible State authorities provided by law and the extensive activities already being carried out. In some instances, much effort has been expended to overcome and correct these unfortunate and wasteful actions. It is urged that the Executive Committee recommend to the Association that: (1) official cognizance be given to this undesirable trend and (2) specific action be taken by the Association to discourage further dispersion in those instances which come to its attention.

Of current significance is the activity in the Department of Commerce, Business and Defense Services Administration which is directed toward collection of data from cities on present water and sewerage systems and future needs. Though originally set up during the Korean War for allocating construction materials under the CMP program, there have subsequently been proposals for perpetuating the unit by assigning to it (the Water and Sewage Industry and Utilities Division) the responsibility for: (a) long range mobilization planning and (b) allocation of Federal funds for water and sewage planning under the public works reserve title of the Housing Act of 1954.(H.R. 7839). The Executive Committee in 1953 recorded its opposition to the above mobilization planning assignment to the Department of Commerce. During the recent session of Congress, your committee indicated its recommendation on the responsibility for the allocation of funds for public works planning. (See top of page 2, Health Officers Newsletter, September 25, 1954.)

Submitted by: Public Health Service

Environmental Sanitation Committee

Equipment Standards for Shellfish Sanitation

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE, IN COOPERATION WITH THE INDUSTRY DEVELOP A SERIES OF STANDARDS COVERING EQUIPMENT OF SPECIAL USE IN THE FIELD OF SHELLFISH SANITATION AND THAT THE SERVICE CONDUCT INSPECTIONS AND ISSUE EQUIPMENT COMPLIANCE LETTERS BASED UPON THESE STANDARDS.

Supporting statement:

Since shellfish sanitation equipment manufactured in one State may be distributed and offered for sale in any or all of the States and Territories, a set of uniform standards and central approval agency that can disseminate information in regard to such equipment to the various States is indicated. With the expansion of the shellfish industry into the field of breading and other processing methods, many special pieces of equipment are being manufactured. This is an activity which most States are not equipped to undertake and it constitutes a real service to the States.

Submitted by: New Jersey Department of Health

Environmental Sanitation Committee

Garbage Feeding to Hogs and the Control of Trichinosis

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. PUBLIC HEALTH SERVICE ENFORCE THEIR INTERSTATE REGULATION TO PREVENT THE USE OF GARBAGE SHIPPED INTERSTATE FROM BEING FED TO HOGS UNLESS PROPERLY COOKED AND FURTHER THAT THEY UNDERTAKE THE PREPARATION OF STANDARDS FOR THE SANITARY OPERATION OF HOG FARMS AS A GUIDE FOR THE USE OF STATE AND LOCAL HEALTH DEPARTMENTS.

Supporting statement:

Trichinosis is recognized as a human disease of concern to health officials and is spread through the consumption of pork from raw-garbage fed pigs. In addition, when garbage is fed to swine, human health hazards and public nuisances multiply due to improper solid and liquid waste disposal, strong odors, fly breeding and the propagation of disease vector rodents.

Submitted by: District of Columbia Department of Public Health
Oregon Board of Health

Environmental Sanitation Committee

Investigation and Evaluation of Possible Hazards to Health of the Newer Insecticides

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PROPER FEDERAL AGENCY INVESTIGATE THOROUGHLY THE POSSIBLE TOXIC EFFECTS ON HUMANS OF THE NEWER INSECTICIDES AND TAKE STEPS TO ENSURE PROPER LABELING BEFORE THEY ARE RELEASED AS "FEDERALLY APPROVED"

THAT REGULATIONS COVERING THE USE OF AUTOMATIC VAPORIZERS IN THE FOOD INDUSTRY FOR THE CONTROL OF INSECTS, VERMIN AND FUNGI BE STUDIED IN RELATION TO THEIR EFFECTIVENESS IN PREVENTING HEALTH HAZARDS TO HUMANS.

Supporting statement:

Insecticides are reaching the State and Territories apparently with "Federal Approval." Many of these are very hazardous and are improperly labled in that the danger and the necessity for protective clothing and equipment are not properly emphasized.

Automatic vaporizers diffuse chemicals which result in additives to exposed food in eating establishments. Laboratory analyses reveal certain foodstuffs such as pies have contained definitive traces of insecticides.

Submitted by; District of Columbia
Department of Public Health

Environmental Sanitation
Committee

Sanitation Problems in Vending Machine Inspections

Action desired:

ADOPTION OF RECOMMENDATION:

THAT PROPER TECHNIQUES BE DEVELOPED FOR SANITIZING BULK DISPENSERS.

Supporting statement:

Existing regulations are not specific.

Bacterial count shows surface contamination within machines; also vermin contamination found inside machines. In addition, there is sometimes careless packing of ingredients at the source.

Submitted by: Public Health Service

Environmental Sanitation Committee

Shellfish-Sanitation Control

Action desired:

ADOPTION OF RECOMMENDATION:

1. THAT THE PRESENT POLICY OF FEDERAL-STATE AND INDUSTRY COOPERATIVE RELATIONSHIP BE CONTINUED INCLUDING THE LISTING OF CERTIFIED SHELLFISH DEALERS BY THE U. S. PUBLIC HEALTH SERVICE BASED ON ITS ENDORSEMENT OF THE VARIOUS STATE PROGRAMS.

2. THAT THE PUBLIC HEALTH SERVICE SHALL DEVELOP SPECIFIC MINIMUM REQUIREMENTS FOR ENDORSING STATE SHELLFISH PROGRAMS WHICH SHALL TAKE INTO ACCOUNT VARYING GEOGRAPHIC AND OTHER CONDITIONS AND THE VARIOUS SPECIES OF SHELLFISH GROWN THEREIN.

3. THAT THE CERTIFICATION OF SHELLFISH PACKERS AND RE-PACKERS, WITH ENDORSEMENT OF SATISFACTORY STATE PROGRAMS BY THE U. S. PUBLIC HEALTH SERVICE, BE DEVELOPED IN ALL RECEIVING STATES.

4. THAT ALL STATES BE ENCOURAGED TO REQUIRE THAT ONLY SHELLFISH FROM CERTIFIED DEALERS BE PERMITTED TO BE SOLD.

5. THAT THE PROGRAM FOR SANITARY CONTROL OF THE SHELLFISH INDUSTRY SHALL BE MAINTAINED THROUGHOUT THE YEAR IN BOTH PRODUCING AND RECEIVING STATES.

6. THAT THE PUBLIC HEALTH SERVICE SHALL MAINTAIN A STAFF TO CARRY OUT ITS RESPONSIBILITY IN THIS PROGRAM, INCLUDING THE NECESSARY RESEARCH AND CONSULTATION SERVICE.

Supporting statement:

As recommended by the Conference of State and Territorial Health Officers at its 1953 meeting, a joint State-Federal-Industry conference was called by the Surgeon General to review the present system of shellfish sanitation in the United States. The conference was held in Washington on September 9-10, 1954 with attendance of about 100 persons representing State and Territorial Health Officers, selected State food and drug officials, other interested Federal agencies, appropriate officials of Canada, and representatives of the shellfish industry. The State and Territorial Health Officers Association was represented by Dr. Mack Shanholtz of Virginia. The Conference of State Sanitary Engineers was represented by Mr. Alfred H. Fletcher, State Sanitary Engineer of New Jersey.

Shellfish Sanitation Control - continued

Items discussed at the conference included: problems in the control of production and marketing of shellfish; Public Health Service participation in shellfish sanitation activities; different sanitary regulations for intrastate and interstate shellfish shippers; importation of shellfish; classification of growing areas; need for specific sanitary requirements for various species of shellfish; and future operation of the shellfish control program.

As a result of these discussions the above resolution was adopted unanimously by the conference. This program is a cooperative venture and depends upon the cooperation of all of the States--interior and coastal alike. Since only 3 of the 22 States represented at the meeting were interior, non-producing States, it is believed that the same resolution should be considered by the Association of State and Territorial Health Officers.

As a means of guiding the cooperative shellfish sanitation program in the future, Mr. David Wallace, Director, Oyster Institute of North America, proposed that an advisory group be established. This group would consist of representatives from all interested parties, State, Federal, and industry, and would meet as necessary.

Submitted by: Oregon Board of Health

Environmental Sanitation Committee

Standards for Air Pollution Control

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. PUBLIC HEALTH SERVICE INITIATE SUCH SURVEYS, STUDIES, AND INVESTIGATIONS OF ATMOSPHERIC POLLUTION AS MAY BE NECESSARY AND APPROPRIATE TO ASSIST THE STATES IN THE ESTABLISHMENT OF STANDARDS FOR MAXIMUM ALLOWABLE CONCENTRATION OF SOLIDS, LIQUIDS, OR GASES WHICH MAY BE PRESENT IN AIR.

Supporting statement:

There is a real need for standards for air cleanliness. Studies and investigations which were conducted in the field of water pollution control by the Public Health Service were of great value to the State in the development of standards and objectives for stream cleanliness. Similar assistance in the development of standards for air cleanliness would permit more rapid progress in State air pollution control programs, would effect a higher degree of uniformity, and would be invaluable to industry and the public, alike.

A G E N D A

HOSPITAL COMMITTEE

Chairman - Robert H. Riley, M.D.	Maryland
Vice-Chairman - John J. Bourke, M.D.	New York

Members

Lovell Bixby	New Jersey
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Liaison

Dr. John W. Cronin	Public Health Service
Miss Ruth Doran	Children's Bureau

Room 3065
HEW Building South
December 6, 1954

HOSPITAL COMMITTEE

1. Appraisal Activities
2. Cooperation with Other Groups
3. Definition of Chronic Disease Hospitals
4. Hearings on State Plan Revisions
5. Hospital Construction Grants-in-Aid Manual
6. New Formula for Estimating T. B. Bed Needs
7. Standards of Bed Adequacy
8. Survey and Planning
9. Survey and Planning Activities
10. Termination Date of Hospital Survey and Construction Program

Submitted by: Public Health Service Hospital Committee

Appraisal Activities

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATES CONTINUE THEIR PROJECT APPRAISAL ACTIVITIES AND THAT THEY BROADEN THE SCOPE OF SUCH ACTIVITIES TO INCLUDE ALL THE TYPES OF FACILITIES WHICH HAVE RECEIVED ASSISTANCE UNDER THE PROGRAM.

Supporting statement:

The provision of hospital and related health facilities, under the Hospital Survey and Construction Program, is predicated upon State surveys and the determination of community needs, and the provision of facilities through which these needs are to be met. A project appraisal mechanism has been developed to provide the States and the Public Health Service with a means for determining the adequacy of State planning, of community planning, evaluation of the project, its physical plant, its equipment, and its utilization. The Division of Hospital Facilities has recognized the need for expanding this appraisal mechanism to include all of the types of facilities constructed under the program.

Submitted by: Public Health Service Hospital Committee

Cooperation with Other Groups

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATES CONTINUE THEIR COOPERATION WITH RELATED HEALTH GROUPS AND, IN THE DEVELOPMENT OF NEW STATE PLANS, COOPERATION IS PARTICULARLY EMPHASIZED WITH STATE AND LOCAL MEDICAL SOCIETIES, NURSING HOMES, AND REHABILITATION GROUPS.

Supporting statement:

The program has been expanded to cover new types of facilities. The administration of the Hospital Survey and Construction Program has been marked by the splendid cooperation of the States and the Public Health Service with hospital associations, professional and other groups.

Submitted by: Tennessee Department of Public Health Hospital Committee

Definition of Chronic Disease Hospitals

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. PUBLIC HEALTH SERVICE, IN CONSULTATION WITH THE HOSPITAL COMMITTEE OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, FORMULATE A DEFINITION OF A CHRONIC DISEASE HOSPITAL.

Supporting statement:

The U. S. Public Health Service has no specific language defining a chronic disease hospital. The absence of such a definition makes it difficult during the annual inventory by States of hospital facilities to properly classify beds in certain institutions, especially where these institutions have chronic disease hospital beds, beds used primarily for nursing purposes, or for that matter, general hospital beds. The new Medical Facilities Law, P. L. 482-83rd Congress, although providing funds for the construction of specific facilities such as nursing homes and chronic disease hospitals, still does not define chronic disease hospitals. In making the annual inventory, the assignment of beds in the several categories will in the future be reflected in the community's priority for Federal aid. Therefore, some specific definitions are necessary.

Submitted by: New Jersey Department of Institutions and Agencies

Hospital Committee

Hearings on State Plan Revisions

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE FEDERAL HOSPITAL COUNCIL AND THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE BE REQUESTED TO RESTUDY THE PRESENT REGULATION REGARDING PUBLIC HEARINGS ON STATE PLANS FOR HOSPITAL AND HEALTH CENTER CONSTRUCTION WITH A VIEW TO ELIMINATING MANDATORY PUBLIC HEARINGS ON REVISIONS TO THE STATE PLANS.

Supporting statement:

The "fair hearing" has been firmly established in all grant-in-aid programs as an adequate administrative device for insuring equitable treatment to beneficiaries of all grant-in-aid programs. In the public assistance program there is no requirement for a "public hearing" each time the State Plan for Public Assistance is revised. Why then should there be a mandatory "public hearing" on the annual revision of the State Plan for Hospitals and Health Centers. The mandatory requirement for "public hearings" is no guarantee of equitable administration, whereas, the fair hearing procedure is a far more certain guarantee that the rights of individual sponsors will be protected.

Submitted by: New Jersey Department of Institutions and Agencies

Hospital Committee

Hospital Construction Grants-in-aid Manual

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE BE REQUESTED TO DISTINGUISH MORE CLEARLY BETWEEN REGULATORY AND POLICY MATERIAL CONTAINED IN MANUAL ISSUANCES RELATING TO THE HOSPITAL CONSTRUCTION PROGRAM.

Supporting statement:

The regulations of the U. S. Public Health Service are constantly being revised as is anticipated in a growing program. However, a clear distinction should be made as to what is a regulation and what is a mere memorandum. At times there is a question whether the memorandum is a supplement to the regulation or whether it is merely suggestive and not mandatory. All instructive material emanating from the Public Health Service should be specifically classified as to whether it is a regulation or a memorandum and a clear definition should be given of the force and effect of both the regulation and the memorandum.

Submitted by: New Jersey Department of Institutions and Agencies

Hospital Committee
Infectious Diseases Committee

New Formula for Estimating T. B. Bed Needs

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE AND THE FEDERAL HOSPITAL COUNCIL BE REQUESTED TO GIVE FURTHER CONSIDERATION TO THE FORMULA FOR DETERMINING THE NUMBER OF BEDS NEEDED TO PROVIDE ADEQUATE HOSPITAL SERVICES FOR TUBERCULOUS PATIENTS.

Supporting statement:

The new formula for estimating T. B. hospital bed needs does not appear to be generally applicable. One and one half times the average annual incidence of tuberculosis in a State over the previous two years may reflect a rather high bed need. The only alternative is to use a substitute formula which is two and one half times the average annual number of deaths over the period from 1940 to 1944. In some States this alternate provision appears inadequate since the average annual number of deaths for the years 1944 to 1954 shows a considerable decline. In some States the present formula indicates that there is no bed need, whereas, the new formula indicates a substantial need for T. B. beds. Further consideration should be given to the establishment of a more adequate formula for estimating bed needs in this category.

Cross reference:

This item should be considered both by the Hospital Committee and the Infectious Diseases Committee for joint recommendation.

Submitted by: Public Health Service Hospital Committee

Standards of Bed Adequacy

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE CONTINUE STUDIES OF PRESENT STANDARDS OF HOSPITAL BED ADEQUACY.

Supporting statement:

There have been changes in the pattern of utilization of hospital service since the inception of the Hospital Survey and Construction Act. It is desirable that the standards of bed adequacy as provided in the Act be studied on a continuing basis in order that changes may be proposed when necessary.

Submitted by: Public Health Service Hospital Committee

Survey and Planning

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE DEVELOPMENT OF A PLAN TO IMPLEMENT THE MEDICAL FACILITIES SECTION OF THE ACT BE COORDINATED WITH A COMPREHENSIVE RE-SURVEY OF EXISTING HOSPITAL CONSTRUCTION PROGRAM IN ORDER TO PROVIDE A PROPER EVALUATION OF NEED AND OF ANTICIPATED USAGE OF FACILITIES AS A BASIS FOR AN INTEGRATED PLAN FOR CONSTRUCTION.

Supporting statement:

The additional facilities made eligible by the Medical Facilities Survey and Construction Act of 1954 makes it possible for a State agency to develop construction programs which will provide communities with Federal assistance to construct almost any type of health facility needed. It is important, therefore, that an integrated program be planned.

Submitted by: Public Health Service Hospital Committee

Survey and Planning Activities

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE SIGNIFICANCE OF THE STATE SURVEYS AND THE DEVELOPMENT OF SOUND AND REALISTIC PROGRAMS FOR ALL TYPES OF FACILITIES BE RE-EMPHASIZED.

Supporting statement:

The provision of hospital and related health facilities, under the Hospital Survey and Construction Program, is predicated upon State surveys and the determination of community needs, and the provision of facilities through which these needs are to be met. Experience has shown also that an inventory and evaluation of community resources and health needs at the time construction is proposed is an excellent assurance of community support for the facility as well as a confirmation of the State agency's recommendations.

Submitted by: California Department of Public Health

Hospital Committee

Termination Date of Hospital Survey and Construction Program

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE BE REQUESTED TO INITIATE DISCUSSIONS WITH REPRESENTATIVES OF STATE HOSPITAL SURVEY AND CONSTRUCTION AUTHORITIES RELATIVE TO THE PROPOSED SEPTEMBER 30, 1957 TERMINATION DATE OF THE PROGRAM AND ITS EFFECT ON FULFILLMENT OF THE PROGRAM'S PURPOSES.

Supporting statement:

Based on information submitted to committees of Congress by the Secretary of Health, Education, and Welfare, as of June 30, 1953, the Nation had only 1,059,816 of the 1,902,089 hospital beds determined to be necessary to provide adequate service to the Nation's population. In view of the successful administration of the Hospital Survey and Construction Program to date, and continuing need for the stimulation furnished through this program in hospital construction, it is important that the present statutory expiration date be extended sufficiently early so that no interruption in programming or planning will occur. It would appear desirable to initiate immediate discussions of the need for extending the program.

A G E N D A

INFECTIOUS DISEASES COMMITTEE

Chairman - T. F. Sellers, M.D.	Georgia
Vice-Chairman - D. G. Gill, M.D.	Alabama

Members

Roy A. Anduze, M.D.	Virgin Islands
John T. Herron, M.D.	Arkansas
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Richard K. C. Lee, M.D.	Hawaii
E. A. Rogers, M.D.	Nebraska

Liaison

Dr. Theodore J. Bauer	Public Health Service
Dr. Marian M. Crane	Children's Bureau

Room G-743-A
HEW Building North
December 6, 1954

INFECTIOUS DISEASES COMMITTEE

1. Amendment of APHA Communicable Disease Control Manual
2. New Formula for Estimating T.B. Bed Needs
3. Rabies Control in Wildlife
4. Regulations Concerning the Importation of Psittacine Birds
5. Report of SubCommittee on Epidemic Intelligence
6. Uniform Reporting of "Infectious Encephalitis"
7. Uniform Standards in Immunization
8. Uniform Statistical Reports by Tuberculosis Hospitals

Submitted by: California Department of Public Health

Infectious Diseases Committee

Amendment of APHA Communicable Disease Control Manual

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATE AND TERRITORIAL HEALTH OFFICERS REQUEST THE APHA TO INCLUDE IN THEIR MANUAL "THE CONTROL OF COMMUNICABLE DISEASES IN MAN," ACCEPTABLE PROCEDURES FOR THE RELEASE OF TYPHOID CARRIERS.

Supporting statement:

In reviewing the rules and regulations of the State Health Departments in the larger states there seems to be fairly close agreement on the definition of a chronic typhoid carrier. However the specified requirements to be met for the release of a chronic carrier vary widely. Some states outline the number of negative stool, urine and bile specimens required following cholecystectomy and these vary as to number of specimens and intervals between collection.

California requires 10 fluid fecal specimens at least 1 month apart, then 2 successive duodenal specimens and 2 additional fecal specimens.

Michigan required 12 fecal specimens at approximately weekly intervals. Then 2 bile specimens or 6 consecutive fecal specimens collected with an identifying dye in a manner satisfactory to the State Health Commissioner and submitted at intervals of approximately 60 days. There is no mention of cholecystectomy.

New York City requires 8 successive stool specimens collected not less than 24 hours apart following cholecystectomy plus 3 duodenal specimens taken not less than 24 hours apart, etc.; also if no cholecystectomy, 5 consecutive negative specimens taken not less than 1 year apart. Then the 8 stool specimens and 3 duodenal specimens as required following cholecystectomy.

New York State requires 8 fecal and urine specimens plus 3 duodenal specimens following cholecystectomy and then the cholecystectomy requirement may be waived if no Vi agglutination properties are found in the blood of the carrier by the State Laboratory.

These illustrations are not expressed as specifically as indicated in the regulations but with just enough detail to bring out the variation. Some states make no mention of cholecystectomy at all.

If there is an acceptable procedure which enables state departments to permit the release of typhoid carriers from the restrictions imposed upon them for the protection of the public health, why shouldn't recommendations for uniform procedures appear in the APHA manual for the guidance of state health departments in revising their regulations.

During 1953 seven typhoid carriers were officially known to have moved from other states to California; ten California carriers moved to other states; there were six visiting carriers--three came visiting in California, two from here went visiting elsewhere and one Californian returned from a visit.

Submitted by: New Jersey Department of Institutions and Agencies

Hospital Committee
Infectious Diseases Committee

New Formula for Estimating T. B. Bed Needs

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE AND THE FEDERAL HOSPITAL COUNCIL BE REQUESTED TO GIVE FURTHER CONSIDERATION TO THE FORMULA FOR DETERMINING THE NUMBER OF BEDS NEEDED TO PROVIDE ADEQUATE HOSPITAL SERVICES FOR TUBERCULOUS PATIENTS.

Supporting statement:

The new formula for estimating T. B. hospital bed needs does not appear to be generally applicable. One and one half times the average annual incidence of tuberculosis in a State over the previous two years may reflect a rather high bed need. The only alternative is to use a substitute formula which is two and one half times the average annual number of deaths over the period from 1940 to 1944. In some States this alternate provision appears inadequate since the average annual number of deaths for the years 1944 to 1954 shows a considerable decline. In some States the present formula indicates that there is no bed need, whereas, the new formula indicates a substantial need for T. B. beds. Further consideration should be given to the establishment of a more adequate formula for estimating bed needs in this category.

Cross reference:

This item should be considered both by the Hospital Committee and the Infectious Diseases Committee for joint recommendation.

Submitted by: New York Department of Health

Infectious Diseases Committee

Rabies Control in Wildlife

Action desired:

ADOPTION OR RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE IN CONJUNCTION WITH THE OTHER APPROPRIATE FEDERAL AGENCIES INVESTIGATE THE POSSIBILITY OF DEVELOPING SAFE, INEXPENSIVE AND EFFECTIVE WILDLIFE CONTROL PROCEDURES AND CONDUCT INVESTIGATIONS INTO RESERVOIRS OF RABIES INFECTION IN WILDLIFE.

Supporting statement:

Rabies in wildlife, and particularly in foxes, has become widely established throughout the United States. The present efforts to control foxes and similar animals have proven inefficient. Further research is needed to determine whether or not there may be a hidden reservoir of infection which maintains the disease in the fox population.

Submitted by: District of Columbia
Department of Public Health

Infectious Diseases
Committee

Regulations Concerning the Importation of Psittacine Birds

Action desired:

ADOPTION OF RECOMMENDATION:

THAT UNIFORM CONTROLS CONCERNING INTERSTATE AND INTRASTATE TRAFFIC IN PSITTACINE BIRDS BE ADOPTED.

Supporting statement:

Since the Federal ban on the interstate shipment of psittacine birds was lifted in 1951 there has been a tremendous increase in the psittacine bird industry. Parakeets have become very popular as house pets. There has also been an increase in bird dealers and breeders and the trading, bartering and exchanging of these birds among breeders often leads to the spread of infection. The control of psittacosis depends largely on the cooperation of breeders and dealers and they are interested in healthy stock and are requesting regulations not only to protect their own activity but to control the disease as well. In view of the importance of this increasing activity, uniform regulations should be adopted in order to reduce the risk of the spread of psittacosis. A regulation such as this, if adopted, should be well publicized and would be supported by public health workers, veterinarians and dealers in psittacine birds.

Submitted by: Subcommittee on Epidemic Intelligence — Infectious Diseases Committee

Report of Subcommittee on Epidemic Intelligence

Action desired:

ACCEPTANCE OF REPORT AND ADOPTION OF ACTIONS RECOMMENDED

Report items:

1. Report of the Technical Advisory Committee on Field Trials of the Salk Polio Vaccine. This Committee is in fact the same as the Sub-Committee on Epidemic Intelligence of the Association's Infectious Diseases Committee. The final responsibility for this report will be that of the National Foundation for Infantile Paralysis, but it should channel through the Association's Executive Committee.

2. Chick Embryo Anti-Rabies Vaccine for Dogs. This is a carry-over item from last year. The Infectious Diseases Committee was directed to report this year. The matter was referred to the Subcommittee on Epidemic Intelligence which recently met in Atlanta and which made the following recommendations: The Subcommittee has reviewed the available evidence on the efficacy of avianized rabies vaccine in dogs, has considered the statement of the Expert Committee on Rabies of the World Health Organization, and endorses the recommendations of that organization as follows:

   "The Committee recognizes that the Chick-embryo vaccine (Flury strain) produces excellent immunity in dogs for at least three years following a single intramuscular inoculation (posterior thigh muscles) and recommends the use of this vaccine in mass immunization programmes.

   "All dogs three months of age and older can be effectively immunized with this product. Although this vaccine appears to be harmless in dogs younger than three months, there is no information yet available concerning its immunizing value in this lower age-range.

   "The Committee also recognizes the efficacy of a single dose of nervous-tissue vaccine, and therefore recommends the use of this type of vaccine for mass vaccinations of dogs in areas where chick-embryo vaccine is not available or is impracticable. Potency tested nervous-tissue vaccine confers good immunity for one year, and three years after vaccination by the intramuscular route there is still significant protection. (See section 9.4, page 19 on paralytic factor.)

Report of Subcommittee on Epidemic Intelligence (cont'd)

"Dogs which have been vaccinated with either vaccine when under six months of age should be revaccinated within the first year of life."

3. National Conference on Trichinosis. The Subcommittee makes the following recommendation:

"Report on Proceedings of the 2nd National Conference on Trichonosis. The Subcommittee recommends that the Association take note of this report and refer the document to the States for study and consideration, but refers its technical aspects to the Committee on Environmental Sanitation for detailed study."

4. American Public Health Association Manual: Control of Communicable Diseases in Man. Since the Subcommittee has had no opportunity to review the contents of the proposed revision of the above manual of the American Public Health Association, it feels that the question of Association endorsement properly devolves upon the Executive Committee of the Association.

5. Manual on Standard Procedure for Investigation of Milk-Borne and Food-Borne Disease Outbreaks. The Subcommittee received and reviewed the proposal of the above manual of the Internation Association of Milk and Food Sanitation. The Subcommittee recommends that this proposal be referred to the forthcoming National Conference of State Epidemiologists and that the International Association of Milk and Food Sanitation be invited to send a representative to that Conference.

6. Polio Gamma Globulin Prophylaxis. This Subcommittee, all of whose members were members of the National Advisory Committee for the Evaluation of Gamma Globulin in the Prophylaxis of Poliomyelitis, considers that the recent evidence submitted by Hammon on further analysis of his work in 1951 and 1952 does not change the evaluation of the actual, practical use of gamma globulin in 1953, which clearly demonstrated that there were no marked dramatic effects produced by its use in household contacts or in so called "community prophylaxis."

It recommends that the published reports of Doctor Hammon be carefully noted in their entirety, and that no attention be given to judgments by others based upon parts of his work taken out of context. He has consistently called attention to the lack of any marked preventive or modifying effect of gamma globulin.

The all important consideration, clearly demonstrated in the 1953 evaluation, is the impossibility of selecting candidates for inoculation with gamma globulin at the right time and in the right place.

Therefore, the Subcommittee recommends that this material be decontrolled.

Report of Subcommittee on Epidemic Intelligence (cont'd)

7. CDC Progress Report on Preparation and Distribution of Diagnostic Reagents.

The CDC has continued to prepare and distribute to a limited extent certain diagnostic reagents for bacteriological identification to strengthen the diagnostic services of the State laboratories. These have consisted primarily of typing sera for Salmonella, Shigella, Escherichia coli, Streptococcus, Pneumococcus, and Meningococcus. In a few instances viral and rickettsial antigens and antisera prepared for CDC use have been shared with certain of the State laboratories to stimulate viral and rickettsial diagnostic activities.

During the current year influenza antigen has been prepared and has been available on request for distribution. Psittacosis complement fixation antigen has likewise been prepared and has been distributed to fourteen State laboratories that have indicated their desire to utilize this antigen.

In order to carry out this recommendation more effectively, a budget and justification have been prepared and submitted for approval. Plans are currently underway to contact the commercial companies who have prepared or have indicated interest in preparing antigens and diagnostic sera in order to develop an effective cooperative program with commercial houses which may ultimately lead to the regular preparation and distribution of these materials on a commercial basis. As funds permit, the CDC will attempt to prepare and/or stockpile antigens and antisera for distribution to State laboratories during this interim period.

Submitted by: California Department of Public Health

Infectious Diseases Committee

Uniform Reporting of "Infectious Encephalitis"

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE BE REQUESTED TO INITIATE STEPS TO MODIFY THE CLASSIFICATION OF REPORTING UNDER THE LABEL "INFECTIOUS ENCEPHALITIS" TO BRING ABOUT SOME UNIFORMITY AND COMPARABILITY OF THE COLLECTED NATIONWIDE STATISTICS.

Supporting statement:

We believe that the present classification of reportable encephalitis as "Infectious encephalitis" is not only unclear but misleading and confusing. It is well known that the clinical syndrome of acute encephalitis may be produced by a variety of etiologic agents including virus, bacteria, fungi, rickettsia, spirochaeta, toxin, physical agents, etc. Which of these are included in the reportable category? The NOVS manual of procedure lists the category 082 as representing this syndrome. Category 343 in the International Statistical Classification of Diseases also includes many illnesses in the encephalitis syndrome.

California has experienced considerable administrative difficulty in the reporting of infectious encephalitis and has recently inaugurated the system of reporting all acute encephalitis by etiology if known or as acute encephalitis, etiology unknown, if that is the case. It appears to us that the time has come to begin breaking up the "waste baskets category" now termed infectious encephalitis into its known and unknown components.

The fact that the plans for the 1955 APHA manual "Control of Communicable Diseases in Man" includes the deletion of the term "infectious encephalitis" substituting the term "arthropod-borne viral encephalitides" in its place lends further cause to the need for some uniform mechanism being found to report the encephalitis syndrome as part of an intelligence system and not one that is dependent upon a laboratory diagnosis prior to report.

Submitted by: District of Columbia
Department of Public Health

Infectious Diseases
Committee

Uniform Standards in Immunization

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THERE SHOULD BE PROMULGATED UNIFORM NATIONAL STANDARDS FOR ADULTS IN THE FIELD OF IMMUNIZATIONS.

Supporting statement:

The problem of immunizations, both in the pediatric and adult groups, is constantly intensified by the shift in attack rates. The increase in international travel with its implications of civil defense makes this a very important public health problem. This is especially true because of the lack of uniformity as to the immunization policies for adults. The organized pediatric groups (i.e. The American Academy of Pediatrics) make recommendations for children, but there is no scientific group making recommendations for adult groups relative to antigens, boosters or special age groups and occupation groups at risks. It would strengthen the field of immunizations should the State and Territorial Health Officers recommend such procedure.

Submitted by: Public Health Service

Federal Relations Committee

Infectious Diseases Committee

Uniform Statistical Reports by Tuberculosis Hospitals

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS COOPERATE WITH THE PUBLIC HEALTH SERVICE, THE AMERICAN HOSPITAL ASSOCIATION, AND THE AMERICAN TRUDEAU SOCIETY IN THE DEVELOPMENT AND INSTALLATION IN TUBERCULOSIS HOSPITALS, OR IN TUBERCULOSIS HOSPITAL SYSTEMS, OF A STANDARDIZED PROCEDURE TO PROVIDE IMPORTANT OPERATING AND PATIENT INFORMATION NECESSARY TO THE INDIVIDUAL HOSPITAL'S SELF EVALUATION, AND TO PROVIDE FOR INTERCHANGE OF COMPARABLE HOSPITAL AND PATIENT MANAGEMENT DATA.

Supporting statement:

Most tuberculosis hospitals prepare annual or biennial reports of their operation. (In some instances these reports are issued under the auspices of the State Health Department. In some instances they are issued by the tuberculosis hospital.) An aggregation of these reports would provide useful information related to tuberculosis hospital operation, to the characteristics of the patients admitted, hospitalized, and discharged, and to the response of patients to hospital treatment. However, the various reports are sufficiently different in their manner of presenting the same information that aggregation of the data presented is not feasible. The Division of Special Health Services of the Bureau of State Services in the Public Health Service is undertaking the task of bringing about greater uniformity in the reports of tuberculosis hospitals and in the tuberculosis reports of health departments so that aggregation of comparable statistics will be available to these organizations. Success in this undertaking will provide essential information for the understanding of tuberculosis hospitalization practices and problems and for the observation of trends in practices, problems and characteristics of the patient population.

Because many tuberculosis hospitals are under the direct control of State and Territorial health officers, and because State and Territorial health officers exercise indirect but none the less real control over many of the hospitals not under their direct jurisdiction, adoption of this recommendation by the Association of State and Territorial Health Officers' will be of inestimable value to the success of this undertaking.

Cross reference:

A recommendation on this item should be made to the Federal Relations Committee by the Infectious Diseases Committee.

A G E N D A

MATERNAL AND CHILD HEALTH COMMITTEE

Chairman - Carlyle G. D. Thompson, M.D.	Montana
Vice-Chairman - Thomas R. Hood, M.D.	Kansas

Members

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Liaison

Dr. Lucille J. Marsh	Children's Bureau

Room G-759-A
HEW Building North
December 5, 1954

MATERNAL AND CHILD HEALTH COMMITTEE

1. Continuing Cooperation with the American Committee on Maternal Welfare and Participation in the Congress of Obstetrics and Gynecology

2. Maternal and Child Health Annual Reporting Requirements

3. School Health Services

Maternal and Child Health
Committee

Continuing Cooperation with the American Committee on Maternal Welfare and Participation in the Congress of Obstetrics and Gynecology

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS REVIEW WITH THE AMERICAN COMMITTEE ON MATERNAL WELFARE, THE ASSOCIATION'S PARTICIPATION IN THE CONGRESS OF OBSTETRICS AND GYNECOLOGY WITH THE INTENTION OF INCORPORATING THE PUBLIC HEALTH ASPECTS IN THE SUBJECT INSOFAR AS IS POSSIBLE AND SUITABLE;

THAT THE STATE AND TERRITORIAL HEALTH OFFICERS ACT THROUGH THE CHAIRMAN OF THE ASSOCIATION'S MATERNAL AND CHILD HEALTH COMMITTEE AND THE STATE AND TERRITORIAL ASSOCIATION OF MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S DIRECTORS;

THAT THE STATE AND TERRITORIAL HEALTH OFFICERS ASSOCIATION ENCOURAGE THE AMERICAN PUBLIC HEALTH ASSOCIATION AND OTHER PUBLIC HEALTH GROUPS TO DO LIKEWISE.

Supporting statement:

For some years, the board of directors of the American Committee on Maternal Welfare has included a representative of the Association of State and Territorial Health Officers who also is active in American Public Health Association affairs. Either he or a person attending in his stead has participated in meetings of committees of the American Committee, and information concerning its purposes, programs and accomplishments has been circulated to key public health officials. In the light of this information, we believe the work of this national organization is worthy of active support by the Association of State and Territorial Health Officers and the American Public Health Association.

A considerable and potentially growing interest in the work of the American Committee and in the Congress of Obstetrics and Gynecology has been observed at recent public health meetings. It is felt, however, that wider dissemination of information concerning the Committee and the Congress could be obtained and additional interest developed through liaison between the American Committee and the maternal and child health committees and organizations mentioned in the second part of the preceding recommendation. Undoubtedly such liaison would lead to increased joint planning and program participation in meetings such as the Congress of Obstetrics and Gynecology by specialists in the public health aspects of maternal health.

Submitted by: New Jersey Department of Health

Federal Relations Committee

Maternal and Child Health Committee

M.C.H. Annual Reporting Requirements

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE U. S. CHILDREN'S BUREAU SIMPLIFY THEIR REPORTING DEMANDS UPON THE SEVERAL STATE MATERNAL AND CHILD HEALTH PROGRAMS TO A COMPARATIVE LEVEL ACHIEVED IN THE CRIPPLED CHILDREN PROGRAM FEDERAL REPORTING.

Supporting statement:

In designing new suggested annual reporting content, the Children's Bureau has assumed that each State has similarly established adequate local and county health departments from whom accurate program activity data can be obtained and collated at the State level. In some States, as in New Jersey, such county and local health departments do not exist. Therefore, federal reporting demands are unrealistic and data necessarily incomplete, resulting in a misleading Maternal and Child Health Program picture. Simplified reporting demands would result in greater comparability between States.

Cross reference:

A recommendation on this item should be made to the Federal Relations Committee by the Maternal and Child Health Committee.

Submitted by: New York Department of Health

Federal Relations Committee

Maternal and Child Health Committee

School Health Services

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE BE REQUESTED TO TAKE THE NECESSARY STEPS TO ESTABLISH COORDINATED FEDERAL LEADERSHIP FOR SCHOOL HEALTH SERVICES.

Supporting statement:

The intrinsic value of school health services has never been satisfactorily evaluated and there are serious doubts as to the worth of many of the types of school health services being carried on. Responsibility for such services is scattered among a variety of agencies on the local level and it would be helpful if there could be established a clear unitary leadership on the Federal level which could correlate information presently available and which would design and help to carry out evaluative studies in the field and give leadership to the school health program.

Cross reference:

This item should be considered both by the Federal Relations Committee and the Maternal and Child Health Committee for joint recommendation.

A G E N D A

MENTAL HEALTH COMMITTEE

Chairman - Grady F. Matthews, M.D.	Oklahoma
Vice-Chairman - W. P. Beckman, M.D.	South Carolina

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Liaison

Dr. Curtis Southard	Public Health Service
Mrs. Elizabeth Ross	Children's Bureau

Room G-751
HEW Building North
December 6, 1954

MENTAL HEALTH COMMITTEE

1. Conference to Delineate Preventive Principles Which Would Find Application to Psychiatric Illness

2. Data on the Epidemiology of Mental Disorder and Mental Retardation

3. Expansion of Research Programs for the Evaluation of Specific Therapies in the Mental Hospital Setting

4. Geriatric Services for the Social-Independent, Non-Psychotic Aging Population

5. Hospitalization of Juvenile Delinquents and Psychopathic Personalities

6. Integration of Mental Health Principles with All Nursing Practice

7. Intensification of Mental Health Programs and Facilities in the Public School System

8. Planning for State Mental Health Programs

9. Rehabilitation of the Mentally Ill

10. State Mental Health Planning

11. State Preventive Mental Health Programs

12. Surveys of Statewide Mental Health Programs

Submitted by: Wisconsin Department of Public Welfare

Mental Health Committee

Conference to Delineate Preventive Principles Which Would Find Application to Psychiatric Illness

Action desired:

ADOPTION OF RECOMMENDATION:

THAT A COMMITTEE BE APPOINTED JOINTLY BY THE STATE MENTAL HEALTH AUTHORITIES AND THE PUBLIC HEALTH SERVICE TO ORGANIZE A CONFERENCE WHICH WOULD HAVE AS ITS PURPOSE THE DELINEATION OF THOSE PREVENTIVE PRINCIPLES WHICH WOULD FIND APPLICATION TO PSYCHIATRIC ILLNESS. THIS SHOULD PROVIDE A FORUM FOR PRESENTATION OF INFORMATION AND DISCUSSION BY BOTH PSYCHIATRISTS AND PUBLIC HEALTH PHYSICIANS.

Supporting statement:

The preventive principle has been outstandingly successful in various medical applications. Reduction of treatment case loads ultimately achieved through prevention more than repays the initial investment in preventive services. There is no way that society can avoid spending money for the sick; there is a choice between investment in adequate health services, with ultimate diminution of case load, or parsimonious present expenditures with increasing case loads. The total case load ultimately forces expenditures far greater than the cost of preventive therapeutic programs.

Physicians in public health work understand preventive programs and public education, but may lack a modern mental hygiene orientation. The content material of preventive psychiatry may be unfamiliar to them, so they may approach the subject with the "organic bias" which does not sufficiently evaluate interpersonal and social factors. Psychiatrists, on the other hand, lack the preventive organization skill of public health. In various ways all over the country, the two groups are finding it desirable and necessary to understand each other and work together. A discussion of common interests would appear most appropriate for this type of meeting.

Submitted by: California Department of Mental Hygiene — Mental Health Committee

Data on the Epidemiology of Mental Disorder and Mental Retardation

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE FEDERAL GOVERNMENT, THROUGH THE NATIONAL INSTITUTE OF MENTAL HEALTH, COOPERATE WITH ONE OR MORE INTERESTED STATES IN CARRYING OUT A CENSUS TO MEASURE THE PREVALENCE OF VARIOUS TYPES AND DEGREES OF MENTAL DISORDER AND MENTAL RETARDATION IN THE GENERAL POPULATION.

Supporting statement:

It is true that a number of small scale surveys have been carried out for this purpose, but none has been sufficiently intensive or extensive to produce results which (with appropriate adjustments to fit local conditions) might be applied to any area in the nation. Obviously, any program of education and prevention must be based upon a reliable knowledge of the extent of the disease in question, if the program is to be efficient and effective. The proposed research should also be of considerable value in planning the future scope and direction of our mental health programs.

Submitted by: California Department of Mental Hygiene

Mental Health Committee

Expansion of Research Programs for the Evaluation of Specific Therapies in the Mental Hospital Setting

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE NATIONAL INSTITUTE OF MENTAL HEALTH AND STATE MENTAL HEALTH AUTHORITIES ENCOURAGE, COORDINATE, AND SUPPORT A COHERENT SERIES OF RESEARCH PROJECTS TO BE CARRIED OUT BY INTERESTED STATE MENTAL HEALTH AUTHORITIES IN DETERMINING THE RELATIVE EFFECTIVENESS OF VARIOUS TYPES OF THERAPY CURRENTLY ADMINISTERED BY STATE MENTAL HOSPITALS.

Supporting statement:

State legislatures are increasingly reluctant to authorize the expansion of therapeutic programs whose efficacy is based largely on subjective medical judgment. To evaluate these therapies relative to each other, a series of scientifically-controlled studies will be required. If it is to produce reliable quantitative results, research of this nature will be both difficult and expensive. Inasmuch as the research findings will be of value to all States, it is felt that the research should be supported at least in part by the Federal Government, and not entirely by the individual States undertaking the research. Federal participation will also insure better over-all coordination in this research area as a whole.

Submitted by: New Jersey Department of Institutions and Agencies
Tennessee Department of Mental Health
Louisiana Department of Institutions

Mental Health Committee

Geriatric Services for the Social-Independent, Non-Psychotic Aging Population

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE IN COOPERATION WITH STATE MENTAL HEALTH AUTHORITIES DESIGN STUDIES AND RESEARCH FOR THE PURPOSE OF DETERMINING THE MOST PRACTICAL METHODS OF HANDLING THE AGING POPULATION WHICH CAN BE ADOPTED BY STATE AND LOCAL COMMUNITIES AND DEVELOP A GENERAL PRACTICAL PATTERN AS TO THE LIMITS OF RESPONSIBILITY OF MENTAL HEALTH FACILITIES IN DEALING WITH THE PROBLEMS OF AN AGING POPULATION.

Supporting statement:

State mental hospitals are bombarded by requests to provide care, custodial or otherwise, for large numbers of aged dependent citizens. Some of these are psychotic, others are merely aged and infirm. As a result there are a great number of non-psychotic, social-independent aging people in State hospitals. The exact percentage is not known. There is reason to believe that there are also many others in the community who are not properly handled. As the population becomes older, this problem will increase. Caring for the aging person in a mental hospital is very expensive. It contributes to overcrowding and it is detrimental to the aging person. Discussions of ways and means of dealing with these problems appears to be an item of general interest.

Submitted by: New Jersey Department of Institutions and Agencies

Mental Health Committee

Hospitalization of Juvenile Delinquents and Psychopathic Personalities

Action desired:

ADOPTION OF RECOMMENDATION:

THAT MODEL LEGISLATION BE DRAFTED WHICH WOULD PROVIDE FOR INSTITUTIONAL CARE OF JUVENILE DELINQUENTS AND PSYCHOPATHIC PERSONALITIES FOR THE PURPOSE OF STUDY, DIAGNOSIS, RECOMMENDATION, AND TREATMENT AND THAT THE ATTENTION OF THE VARIOUS STATES AND TERRITORIES BE CALLED TO THE NEED FOR SPECIAL AND PROPER FACILITIES IN WHICH JUVENILE DELINQUENTS OR PSYCHOPATHIC PERSONALITIES MAY BE RECEIVED, STUDIED, AND TREATED SEPARATE FROM ESTABLISHED MENTAL HOSPITALS.

Supporting statement:

At the present time there is no uniformity of legislation in the States for institutionalizing juvenile delinquents. Consequently, juvenile offenders are housed with adult criminals or with mentally ill patients. In order to get the most effective results from treatment of these offenders, specialized studies in separate institutions by a specialized staff are indicated.

Few, if any, States provide adequate institutional care for the study and treatment of juvenile delinquents. Too many states hospitalize these individuals in established mental hospitals which may be harmful to them.

Submitted by: District of Columbia
Department of Public Health

Mental Health
Committee

Integration of Mental Health Principles With all Nursing Practice

Action desired:

ADOPTION OF RECOMMENDATION:

THAT MENTAL HEALTH PRINCIPLES BE INTEGRATED INTO ALL NURSING PRACTICE AND TO THIS END THAT EMPHASIS BE PLACED ON MENTAL HEALTH EDUCATION FOR ALL NURSES.

Supporting statement:

It is known that nurses compose the largest numerical group of health workers both in hospitals, institutions and public health agencies. Hence, they are in contact with the greatest number of individuals and families and can influence desirable attitudes conducive to positive mental health habits from infancy to old age.

In every community there is tremendous pressure for the treatment of the mentally ill, but in the long run, reduction in the amount of mental illness lies in sound measures for prevention.

In the past mental health activities have been separated as specialties and have not been an integral part of the general health programs. The utilization of mental health principles by nurses in all places of work would assist in overcoming the isolation and insulation of mental health programs.

Submitted by: California Department of Mental Hygiene

Mental Health Committee

Intensification of Mental Health Programs and Facilities in the Public School System

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATES UNDERTAKE, AS A MATTER OF FORMAL POLICY, THE IMPLEMENTATION AND SUPPORT OF A PROGRAM FOR ENCOURAGING INTENSIFIED MENTAL HEALTH ACTIVITIES IN THE PUBLIC SCHOOL SYSTEM:

1) THROUGH TEACHER-TRAINING IN THE PRINCIPLES OF GOOD MENTAL HEALTH AND METHODS FOR DETECTING MENTAL OR EMOTIONAL DISORDER IN ITS EARLY STAGES,
2) THROUGH ADEQUATE PROVISION FOR A MENTAL HEALTH STAFF IN EACH SCHOOL SYSTEM TO INCLUDE PSYCHIATRISTS, PSYCHOLOGISTS AND SOCIAL WORKERS,
3) THROUGH AN EFFECTIVE PROGRAM FOR THE DISMISSAL OF EMOTIONALLY DISTURBED OR MENTALLY ILL TEACHERS,
4) THROUGH IMPROVED COORDINATION OF THE EFFORTS OF TEACHER, PARENT AND COMMUNITY IN REARING MENTALLY HEALTHY CHILDREN.

Supporting statement:

Community programs for teaching of mental health principles and for the prevention of emotional and mental disorders generally reach only the people who have already developed an interest in this field. A more far reaching and more fully effective mental health program can be carried out through the public school system.

Submitted by: Public Health Service

Mental Health Committee

Planning for State Mental Health Programs

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ATTENTION OF THE COUNCIL OF STATE GOVERNMENTS BE CALLED TO THE DESIRABILITY OF INCLUDING THE STATE MENTAL HEALTH AUTHORITY RECEIVING FEDERAL GRANTS-IN-AID OR THE DIRECTOR OF THE STATE MENTAL HEALTH PROGRAM OR BOTH (WHEN SEPARATE) AMONG THE MEMBERS OF STATE-WIDE MENTAL HEALTH PLANNING COMMITTEES IN ORDER THAT EQUAL CONSIDERATION BE GIVEN TO ALL FACETS OF THE MENTAL HEALTH PROGRAM--PREVENTIVE, THERAPEUTIC, AND REHABILITORY.

Supporting statement:

The Council of State Governments has developed a strong interest in the care and prevention of mental illness and in surveying the needs for research and training. In order to make the most effective use of existing personnel and facilities, avoid duplication of effort, establish priority of need and use budgetary appropriations effectively, the cooperation of key personnel in all State mental health activities is necessary.

During the past year there have been several instances of State and regional planning for mental health activities which have not included the director of State mental health programs or personnel from the agency receiving mental health grants-in-aid.

Submitted by: Public Health Service

Mental Health Committee

Rehabilitation of the Mentally Ill

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE STATE AND TERRITORIAL HEALTH OFFICERS' ASSOCIATION REAFFIRM THE ACTION TAKEN BY THE ASSOCIATION IN 1952 TO RECOMMEND THAT THE STATE MENTAL HEALTH PROGRAM DIRECTOR TAKE APPROPRIATE ACTION TO ENCOURAGE THE INCLUSION OF PERSONS SUFFERING FROM MENTAL ILLNESS AND MENTAL DEFECT IN REHABILITATION PROGRAMS.

Supporting statement:

The 83rd Congress of the United States passed Public Law 565 as an amendment to the Vocational Rehabilitation Act so as to "promote and assist in the extension and improvement of vocational rehabilitation services, provide for a more effective use of available Federal funds and otherwise improve the provisions of that Act, and for other purposes." An appropriation of 30 million dollars for the current fiscal year will make possible the extension of grants-in-aid to States to assist them in:

(1) Meeting the costs of vocational rehabilitation services,

(2) Initiating projects for extension and improvement of such services, and

(3) Assisting in meeting the costs of projects for research demonstrations, training and other special projects.

Under Section 11(a) (1) rehabilitation services are defined to include "corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and constitutes a substantial handicap to employment, but is of such a nature that such correction or modification may reasonably be expected to eliminate or substantially reduce such handicap within a reasonable length of time."

Under Section 11(b) of this Act a handicapped individual is defined as "any individual who is under a physical or mental disability which constitutes a substantial handicap to employment, but which is of such a nature that vocation rehabilitation services may reasonably be expected to render him fit to engage in a remunerative occupation."

Submitted by: Public Health Service

Mental Health Committee

State Mental Health Planning

Action desired:

ADOPTION OF RECOMMENDATION:

THAT STATE DIRECTORS OF MENTAL HEALTH PROGRAMS BE URGED TO DEVELOP EFFECTIVE METHODS FOR KEEPING THE GOVERNING BODY OF THE INDIVIDUAL STATE CURRENTLY INFORMED ON MENTAL HEALTH PROGRAMS IN ORDER TO INVITE INCLUSION OF THE MENTAL HEALTH PROGRAM DIRECTOR IN ALL STATE GOVERNMENT PLANNING FOR MENTAL HEALTH ACTIVITIES.

Supporting statement:

The National Mental Health Act made provision for flexible arrangements for the appointment of a State mental health agency to receive grant-in-aid funds. This fact plus the fact that large State appropriations are requested for patient care in State mental hospitals tends to obscure the need for planning and appropriations for educational and preventive activities over and above those related to the care and rehabilitation of persons already mentally ill.

In order to make the best use of the limited personnel in the already existing Statewide services and to avoid duplication of and confusion of planning, it becomes important that State officials and legislatures be fully aware of existing resources.

The application of this principle to regional planning should also be considered so that national bodies such as the Council of State Governments be kept informed of current regional planning in the field of mental health; for example, the meetings of State Mental Health Authorities and State mental health clinic personnel under the auspices of Public Health Service regional offices.

Submitted by: Iowa Mental Health Authority

Mental Health Committee

State Preventive Mental Health Programs

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS URGE ALL STATES TO MAKE SPECIFIC APPROPRIATIONS OF STATE FUNDS FOR PSYCHIATRIC CLINICS AND MENTAL HEALTH EDUCATION.

Supporting statement:

Training, research and community services are the core of a preventive mental health program. Training and research will receive appropriate emphasis through Regional Conferences and the National Governor's Conference.

With decreased federal grants-in-aid for mental health, the present psychiatric clinics may be jeopardized. While there is popular interest in extending clinic services into new areas, adequate state funds should be appropriated to stabilize existing clinics and to encourage mobile or multi-county units.

Submitted by: Public Health Service

Mental Health Committee

Surveys of Statewide Mental Health Programs

Action desired:

ADOPTION OF RECOMMENDATION:

THAT WHEN STATEWIDE SURVEYS OF MENTAL HEALTH PROGRAMS ARE CONTEMPLATED THE STATE MENTAL HEALTH AUTHORITY SHOULD TAKE LEADERSHIP IN:

1) PULLING TOGETHER EXISTING INFORMATION FROM PREVIOUS SURVEYS, STUDIES AND OTHER SOURCES,

2) COORDINATE THE PLANNING FOR THE PRESENT SURVEY WITH ALL OF THE AGENCIES CONCERNED WITH MENTAL HEALTH WITHIN THE STATE.

Supporting statement:

In order to avoid piecemeal surveys, duplication of studies and evaluation by inexperienced or unqualified resource personnel, State agencies should seek consultation as to the most effective and productive sources of survey personnel. The regional mental health consultants offer one resource for consultation to State groups who desire assistance in the planning of survey activities.

There are at present several possible sources of Statewide surveys of mental health programs among which are the following:

(1) Council of State Governments (as illustrated by SREB),

(2) The American Psychiatric Association State Survey Committee,

(3) NIMH State hospital survey service,

(4) State planning commissions,

(5) Private survey agencies.

Joint planning for a Statewide survey should include at least the following items:

(1) Development of a representative advisory committee.

(2) Outline the objectives of the survey.

(3) Identify the problems to be studied.

(4) Collecting and evaluating the extent of existing information, facilities and personnel.

(5) Set up tentative budget for making the survey and compiling the report.

(6) Preliminary planning for implementing the recommendations of the survey group.

(7) Deciding which of the available survey resources is most applicable in the given situation.

A G E N D A

SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE

Chairman - C. Earl Albrecht, M.D.	Alaska
Vice-Chairman - George A. Spendlove, M.D.	Utah

Members

Gerald R. Clark, M.D.	New Mexico
John A. Kahl, M.D.	Washington
Stanley H. Osborn, M.D.	Connecticut
Juan A. Pons, M.D.	Puerto Rico
John Samuel Wheeler, M.D.	New Hampshire

Liaison

Dr. Seward Miller	Public Health Service
Dr. Alice D. Chenoweth	Children's Bureau

Room G-755
HEW Building North
December 6, 1954

SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE

1. Cooperation with Agricultural Extension Service in Health Programs for Farm Families

2. Determination of the Role of Health Department in Community Chronic Disease Activities

3. Meeting of Chronic Disease Program Directors

4. Nursing Homes

5. Payment of Non-Resident Tuberculosis Medical and Hospital Costs

6. Rehabilitation Facilities

Submitted by: Public Health Service

Special Health and Medical Services Committee

Cooperation with Agricultural Extension Service in Health Programs for Farm Families

Action desired:

ADOPTION OF RECOMMENDATION:

THAT A JOINT COMMITTEE BE ESTABLISHED REPRESENTING THE PUBLIC HEALTH SERVICE, THE CHILDREN'S BUREAU, THE EXTENSION DIVISION OF AGRICULTURE, AND THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS, TO EXPLORE WAYS IN WHICH HEALTH AND AGRICULTURAL AGENCIES CAN WORK MOST PRODUCTIVELY FOR THE HEALTH OF FARM FAMILIES, AND THAT THE PUBLIC HEALTH SERVICE TAKE THE INITIATIVE IN CALLING THE FIRST ORGANIZATION MEETING OF THE COMMITTEE.

Supporting statement:

The Extension Service of Agriculture assists farm families in changing their farm and home practices so that rural people may enjoy an improved standard of living. Because of the close working relation between agricultural extension agents and the rural people, there are many opportunities for such workers to interpret public health to the people. In some States Agricultural Extension Departments have employed a health specialist to work with the local extension agents. There is need for such Specialists to work closely with the State Department of Health.

Satisfactory cooperative arrangements have been developed in a few States. The function of the proposed committee would be to study the methods developed in these States, publicize them and develop such other means as the committee may see fit to help Health and Agriculture Agencies pool their resources for improving the health practices of the farm population.

Submitted by: Public Health Service

Special Health and Medical Services Committee

Determination of the Role of Health Department in Community Chronic Disease Activities

Action desired:

ADOPTION OF RECOMMENDATION:

A. THAT A CHRONIC DISEASE SUB-COMMITTEE OF THE SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE BE ESTABLISHED WITH MEMBERSHIP CONSISTING OF STATE AND/OR TERRITORIAL HEALTH DEPARTMENT REPRESENTATIVES APPOINTED BY THE CHAIRMAN OF THE SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE.

B. THAT THIS CHRONIC DISEASE SUB-COMMITTEE MEET AT LEAST TWICE DURING THE COMING YEAR TO CONSIDER THE ROLE OF THE HEALTH DEPARTMENT IN COMMUNITY CHRONIC DISEASE ACTIVITIES AND MAKE RECOMMENDATIONS FOR CONSIDERATION BY THE SPECIAL HEALTH AND MEDICAL SERVICES COMMITTEE AT THE 1955 CONFERENCE OF THE SURGEON GENERAL WITH STATE AND TERRITORIAL HEALTH OFFICERS IN THE FIELD OF SUCH ACTIVITIES IN CHRONIC DISEASE AS:

1. Evaluation and definition of problems
2. Prevention
3. Detection
4. Care and rehabilitation
5. Social and economic adjustment
6. Research

Supporting statement:

A. In the last few years, attention has been directed by the Committee on Special Health and Medical Services to various facets of the chronic disease field; e. g., education of the general practitioner in diagnosis and treatment of heart disease (1948), conduction by health departments of mass screening for detection of diabetes (1949), studies of the needs of the aging population in respect to chronic disease hospitals, nursing home services, medical care (1952). It is felt that now is the time to give special consideration to the role of the health department in the total chronic disease program and that a special committee is necessary to develop such consideration.

B. To discharge their responsibilities properly, the members of the committee would have to assemble at least twice during the year, the secretariat activities being performed by Public Health Service consultants who could devote a greater amount of their time to such activities. It is suggested that sub-committee membership include personnel in State or Territorial Health Departments who are active in chronic disease programs.

Submitted by: Pennsylvania Department of Health

Special Health and Medical Services Committee

Meeting of Chronic Disease Program Directors

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COOPERATE WITH THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS IN ORGANIZING AND CONDUCTING A MEETING OF ALL CHRONIC DISEASE CONTROL PROGRAM OFFICERS AT STATE HEALTH DEPARTMENT LEVEL IN ORDER TO DISCUSS THE EXTENT OF THEIR PRESENT DUTIES, TO OUTLINE A DESIRABLE NATION-WIDE APPROACH TO THIS PROBLEM THROUGH STATE HEALTH DEPARTMENTS, AND THAT STATISTICIANS BE PRESENT IN ORDER TO DISCUSS THE PROBLEM OF MORBIDITY REPORTING.

Supporting statement:

This is an area of increasing importance where much of the course is still unchartered and such a meeting should be beneficial to the chronic disease control programs throughout the nation. While it is undesirable to have any more meetings of specified program directors than are necessary, it would seem that there is much benefit to be derived by a meeting of chronic disease control directors of the various states. Such a meeting, like those of other specialty directors, could be held once every two years.

Submitted by: New York Department of Health Special Health and Medical Services Committee

Nursing Homes

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE RESPONSIBILITIES OF STATE AND LOCAL HEALTH OFFICERS IN THE SUPERVISION OF NURSING HOMES BE AFFIRMED AND THE RESPECTIVE STATES BE URGED TO EMPHASIZE ACTIVITIES IN THIS AREA.

Supporting statement:

With the conquest of acute communicable diseases and our rapidly aging population, nursing homes are steadily assuming greater importance. There is ample evidence that standards for nursing homes are deplorably low in most communities. It has been suggested that the development of standards of care in nursing homes and their supervision should be considered definite responsibilities of state and local health officers.

Submitted by: California Department of Public Health
New Jersey Department of Health

Special Health and Medical Services Committee

Payment of Non-Resident Tuberculosis Medical and Hospital Costs

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE BE REQUESTED TO DEVELOP A PLAN IN COOPERATION WITH OTHER FEDERAL AND STATE HEALTH AND WELFARE AGENCIES TO PROVIDE FOR MEDICAL AND HOSPITAL TREATMENT OF ALL NON-RESIDENT TUBERCULOSIS PATIENTS WHO ARE UNABLE TO PAY FOR THEIR OWN CARE.

Supporting statement:

Although this problem was recognized in the proceedings of the Association of State and Territorial Health Officers at their annual meeting in 1950, it seems timely to take up the matter again. Welfare agencies have recently presented before Congress (November, 1953) the problem of residency requirements for welfare benefits.

Efforts are also being made to secure the elimination of residency requirements in order to secure benefits for certain groups such as those officially classified as "migrants."

The efforts being made by welfare agencies to elimate residency requirements might be strengthened by action on the part of health agencies to avoid the spread of tuberculosis as can happen now when delays occur in providing medical care and hospitalization of infected persons while investigation of residency status of the person is being made. If legal residency is confirmed in another State, the practice of returning the individual to that State by public conveyance may be a further menace to health.

Tuberculosis is a communicable disease which at present requires considerable hospital and surgical treatment. In view of the mobility of population in the United States, Federal subsidy for patients who become ill in States not of their residence would equalize the welfare burden on States having to care for non-residents. Lack of such financial assistance causes some States to put undue pressure on patients to return to the State of their residence.

A uniform nation-wide plan for Federal assistance to the States in order that they could provide medical care and immediate hospitalization for any person infected with tuberculosis would be of great assistance in the tuberculosis control program.

Submitted by: New York Department of Health Special Health and edical Services Committee

Rehabilitation Facilities

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS TAKE APPROPRIATE STEPS TO DEVELOP AND ADOPT A DEFINITION OF THE RESPONSIBILITY OF STATE AND LOCAL HEALTH OFFICERS WITH REGARD TO REHABILITATION.

Supporting statement:

Studies have shown that only a small percentage of persons who could benefit from modern rehabilitation techniques are receiving adequate treatment, and that there is a nationwide dearth of rehabilitation facilities and trained personnel. The function of the health department in rehabilitation has not been well defined. Recent provisions of the Hill-Burton Act call attention to the need for such definition.

A G E N D A

CIVIL DEFENSE COMMITTEE

Chairman - Albert E. Heustis, M.D.	Michigan
Vice-Chairman - Stanley H. Osborn, M.D.	Connecticut

Members

Roland R. Cross, M.D.	Illinois
Herman E. Hilleboe, M.D.	New York
Malcolm H. Merrill, M.D.	California
Russell E. Teague, M.D.	Pennsylvania

Liaison

Dr. LeRoy E. Burney	Public Health Service
Dr. Katherine Bain	Children's Bureau

District Room
Washington Hotel
December 5, 1954
12:30 P.M.

CIVIL DEFENSE COMMITTEE

1. Operational Manuals for Improvised Hospitals and First-Aid Stations

2. Registration and Identification of the Population

3. Surplus Federal Equipment and Supplies for Civil Defense

Submitted by: Oregon Board of Health
District of Columbia
Department of Public Health

Civil Defense
Committee

Operational Manuals for Improvised Hospitals
and First Aid Stations

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE FEDERAL CIVIL DEFENSE AGENCY COMPLETE AT AN EARLY DATE DETAILED ORGANIZATIONAL AND OPERATIONAL MANUALS ON IMPROVISED EMERGENCY HOSPITAL AND FIRST AID STATION OPERATIONS WHICH WILL INCLUDE UNIFORM NOMENCLATURE AND UNIT MANNING EQUIPMENT AND SUPPLY LISTS BASED ON FEDERAL CIVIL DEFENSE AGENCY TRAINING MANUALS.

Supporting statement:

Uniform nomenclature, organization, and equipment and supply lists would facilitate requests for aid and use on arrival of civil defense medical first aid and improvised hospital units. It would be of real assistance to the States and Territories if operational manuals based on FCDA training manuals could be prepared by the Federal Civil Defense Agency and could be made available at an early date. If States and Territories are to proceed with training and exercises operating first-aid stations and improvised emergency hospitals, these manuals will have to be developed. If it is done on a State and Territorial level, there will be much duplication of effort and excessive cost of production.

Submitted by: Oregon Board of Health Civil Defense Committee

Registration and Identification of the Population

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE CIVIL DEFENSE COMMITTEE OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS STUDY AND MAKE RECOMMENDATIONS ON THE ADVISABILITY OF ADOPTING A SYSTEM OF REGISTRATION OF ALL CITIZENS TO ASSIST IN THE IDENTIFICATION OF WAR-CAUSED OR OTHER CIVIL DISASTER CASUALTIES.

Supporting statement:

In a large-scale disaster, identification of casualties and disposition of the dead must proceed in an orderly fashion, and it is dependent upon the effectiveness of the system used for the identification of casualties. Recommendations should be made and procedures standardized on a national basis.

Submitted by: California Department of Public Health

Civil Defense Committee

re: Surplus Federal Equipment and Supplies for Civil Defense

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE APPROPRIATE FEDERAL AGENCIES BE REQUESTED TO SET UP ARRANGEMENTS WHEREBY CERTAIN SURPLUS FEDERAL EQUIPMENT AND SUPPLIES CAN BE PROCURED BY STATE CIVIL DEFENSE AGENCY TO BE USED IN CIVIL DEFENSE PROGRAMS.

Supporting statement:

From time to time, certain surplus supplies such as canteens, and belts, 5 gallon water cans, beds, mattresses, auxiliary power units, etc., are declared surplus by the Defense Department. This type of equipment is badly needed by State Civil Defense Agencies.

It would seem appropriate to allow State and Local Civil Defense organizations to have the opportunity to select from these surplus stores such items as they can use before offering them for public sale.

A G E N D A

SPECIAL COMMITTEE ON MIGRANT LABOR

Chairman - Roy L. Cleere, M.D. Colorado

Members

C. Earl Albrecht, M.D.	Alaska
Daniel Bergsma, M.D.	New Jersey
Albert B. Heustis, M.D.	Michigan
Herman E. Hilleboe, M.D.	New York
R. H. Hutcheson, M.D.	Tennessee
Malcolm H. Merrill, M.D.	California
Carl N. Neupert, M.D.	Wisconsin
J. W. R. Norton, M.D.	North Carolina
Clarence G. Salsbury, M.D.	Arizona
Wilson T. Sowder, M.D.	Florida
John A. Kahl, M.D.	Washington

Liaison

Dr. Donald Harting	Public Health Service
Dr. Katherine Bain	Children's Bureau

Capital Room
Washington Hotel
December 5, 1954
2:00 P.M.

SPECIAL COMMITTEE ON MIGRANT LABOR

1. Federal Migratory Labor Appropriations and Related Legislation

2. Financing of Medical Services for Migratory Workers

3. Migrant Labor

4. Migratory Agricultural and Food Processing Labor from Outside the Continental United States

5. Regional Conferences on Migratory Agricultural and Food Processing Labor

6. Suggested Specific Studies by the Special Committee and State Health Officers

Submitted by: Special Committee on Migrant Labor, Association of State and Territorial Health Officers

Special Committee on Migrant Labor

Federal Migratory Labor Appropriations and Related Legislation

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE PUBLIC HEALTH SERVICE, CHILDREN'S BUREAU, AND BUREAU OF PUBLIC ASSISTANCE PROVIDE TO THE STATES FROM WHICH THE MIGRATORY AGRICULTURAL AND FOOD PROCESSING LABOR FLOWS AND TO THOSE ALONG THE MIGRATORY ROUTES, SUPPLEMENTARY FUNDS, ON A CONTINUING BASIS, FOR STRENGTHENING AND INCREASING BASIC LOCAL HEALTH SERVICES; FOR SEASONAL SUPPLEMENTATION OF STATE AND LOCAL HEALTH AND WELFARE STAFFS; AND FOR COORDINATION OF STATE AND INTERSTATE MEDICAL-SOCIAL AND WELFARE SERVICES RELATED TO THE EMERGENCY MEDICAL, DENTAL, HOSPITAL, AND ASSOCIATED SUBSISTENCE AND WELFARE NEEDS OF THE MIGRANTS;

THAT ALL RESIDENCE REQUIREMENTS FOR WORKERS IN AGRICULTURE OR FOOD PROCESSING BE WAIVED OR INTERPRETED LIBERALLY IN THE USE OF SUCH FUNDS;

THAT THE PUBLIC HEALTH SERVICE AND THE CHILDREN'S BUREAU ALSO PROVIDE TO THE STATES SPECIAL GRANTS FOR PILOT STUDIES AND PROGRAMS FOR IMPROVING THE HEALTH CONDITIONS OF THE MIGRATORY WORKERS AND THEIR FAMILIES;

THAT, IN RECOMMENDING TO THE CONGRESS APPROPRIATIONS FOR BASIC HEALTH SERVICES FOR THE TOTAL POPULATIONS OF THE STATES, ESPECIALLY FOR CONTROLLING COMMUNICABLE DISEASES SUCH AS VENEREAL DISEASE AND TUBERCULOSIS, THE CONTINUING AND RAMIFYING INTRASTATE RISKS OF SPREAD OF DISEASE FROM AND AMONG THE MIGRANTS BE BORNE IN MIND;

THAT IN PROVIDING FUNDS FOR MIGRATORY LABOR PROGRAMS, THE PUBLIC HEALTH SERVICE AND THE CHILDREN'S BUREAU COOPERATE TO ELIMINATE RIGID CATEGORICAL RESTRICTIONS ON THE USE OF THE FUNDS, WHICH WOULD TEND TOWARD SEGMENTED ATTACK UPON THE PROBLEM (SUCH AS EMPHASIS ON THE HEALTH OF THE CHILDREN AND MOTHERS ONLY, OR ON THE HEALTH OF THE LABORERS ONLY) INSTEAD OF SOLUTION OF THE INTERRELATED PROBLEMS OF THE WHOLE MIGRATORY GROUP;

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS COOPERATE WITH THE FEDERAL AGENCIES IN SEEKING THE RECOMMENDED APPROPRIATIONS AND IN SPONSORING ANY FEDERAL LEGISLATION NEEDED IN THAT REGARD.

Supporting statement:

The recommendations concerning provision of Federal funds are similar in intent to several made by the East Coast Migrant Conference, but the Special Committee of the Association proposes such funds for all regions with migratory agricultural and food processing labor problems.

Federal Migratory Labor Appropriations
and Related Legislation - Continued

Supporting statement:

Health examination and follow-up studies among migrants that have been summarized for the Special Committee show a high incidence of venereal disease among examined migratory labor groups; the presence of tuberculosis; the difficulty of complete case follow-up and cure or isolation; and the movement of cases, when brought under care, back into the population of the States of employment and of residence while in infectious stages.

The recommended avoidance of rigid categorical restrictions in use of funds for migratory labor programs is based, in part, upon difficulties experienced by State health officers in planning the most effective use of categorical funds, in general; and also upon recent experience of a few of the State health departments, such as that of Colorado, in drawing up proposals for migratory labor studies and programs under special allotments from categorical funds.

Submitted by: California Department of Public Health

Special Committee on Migrant Labor

Financing of Medical Services for Migratory Workers

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE SPECIAL COMMITTEE ON MIGRANT LABOR BE REQUESTED TO STUDY FEDERAL-STATE FINANCING OF MEDICAL SERVICES FOR MIGRATORY WORKERS AND THEIR FAMILIES. (THIS ITEM MAY VERY LIKELY HAVE BEEN DISCUSSED BY THIS GROUP: AND/OR IT MAY BE CONSIDERED ESSENTIALLY A WELFARE RESPONSIBILITY).

Supporting statement:

Many migratory workers are non-residents of the State in which they are employed and, therefore, are not eligible for publicly supported medical services in the community in which they are working. Ill health among the migrant group may serve to depress the level of health in the community as a whole.

Submitted by: Pennsylvania State Department of Health

Special Committee on Migrant Labor

Migrant Labor

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS URGE ALL STATE HEALTH AGENCIES TO COORDINATE THEIR EFFORTS AT THE STATE LEVEL TO ASSURE A CONTINUOUS PREVENTIVE PROGRAM THROUGH IMMUNIZATION AND TREATMENT; WITH THE DEVELOPMENT OF A RECORD SYSTEM WHICH WOULD PROVIDE THE MIGRANT LABORERS AS THEY TRAVEL FROM SECTION TO SECTION WITH A RECORD OF CLINICAL EXAMINATIONS, LABORATORY EXAMINATIONS, TREATMENT RECEIVED AND NEEDED.

Supporting statement:

Regional committees on migrant labor have been working on this subject and reports from these groups will, undoubtedly, be available at the State and Territorial Health Officers meeting. Movement of seasonal migrant laborers poses a number of health problems, both to the migrant group and to the areas to which they move, and the development of a uniform record system and health survey system is highly desirable.

Submitted by: Special Committee on Migrant Labor, Association of State and Territorial Health Officers

Special Committee on Migrant Labor

Migratory Agricultural and Food Processing Labor from Outside the Continental United States

Action desired:

ADOPTION OF RECOMMENDATION:

THAT ENFORCEMENT OF EXISTING STATE, TERRITORIAL, FEDERAL, AND INTERNATIONAL LAWS AND REGULATIONS AND AGREEMENTS REGARDING THE HEALTH EXAMINATION, HEALTH CONDITIONS, ENTRY INTO AND DEPARTURE FROM THE CONTINENTAL UNITED STATES, AND RELATED MATTERS BE STRENGTHENED IN EVERY WAY POSSIBLE:

THAT THE STATE AND TERRITORIAL OFFICERS OF THE REGIONS IN WHICH MIGRATORY LABOR FROM OUTSIDE THE CONTINENTAL UNITED STATES POSES SERIOUS PROBLEMS PREPARE A STATEMENT OF THE NEEDED FURTHER FEDERAL MEASURES, AND THAT THE SPECIAL COMMITTEE OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS TAKE LEADERSHIP IN SPONSORING SUCH LEGISLATION.

Supporting statement:

Although the problems of migratory labor from outside the Continental United States could not be thoroughly studied by the Special Committee in 1954, a number of reports and conferences between various State health officers and the chairman served to emphasize the seriousness of these problems and the many types of action needed.

Submitted by: Special Committee on Migrant Labor, Association of State and Territorial Health Officers

Special Committee on Migrant Labor

Regional Conferences on Migratory Agricultural and Food Processing Labor

Action desired:

ADOPTION OF RECOMMENDATION:

THAT ALL STATE HEALTH OFFICERS BE FURNISHED COPIES OF THE RECOMMENDATIONS AND PROCEEDINGS OF THE EAST COAST MIGRANT CONFERENCE, MAY 17-19, 1954, AS SOON AS POSSIBLE;

THAT THE SPECIAL COMMITTEE ON MIGRANT LABOR OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS CONTINUE TO STUDY THE RECOMMENDATIONS OF THE EAST COAST CONFERENCE AND TO IMPLEMENT THEM IN THAT REGION, AND IN ALL OTHER REGIONS, INSOFAR AS APPLICABLE;

THAT THE FEDERAL AGENCIES WHICH SPONSORED THE EAST COAST CONFERENCE ARRANGE FOR EARLY CONFERENCES IN ALL OF THE OTHER REGIONS WITH MIGRATORY AGRICULTURAL AND FOOD PROCESSING LABOR PROBLEMS FOR THE PURPOSE OF DELINEATING THE PROBLEMS PECULIAR TO THE OTHER INDIVIDUAL REGIONS AND OF RECOMMENDING THE STATE, REGIONAL, AND FEDERAL ACTION REQUIRED FOR SOLUTION OF THE SPECIAL REGIONAL PROBLEMS.

Supporting statement:

Preliminary reports received by the Special Committee of the Association of State and Territorial Health Officers regarding the East Coast Migrant Conference carry requests for cooperation of the Special Committee in implementing the Conference's recommendations. The Special Committee has studied the reports and recommendations in relation to information received from State health officers regarding migratory agricultural labor problems, programs, and suggested solutions in other regions. It appears from the Special Committee's review that many of the problems are similar in type in all regions; whereas some other problems, such as those relating to migratory labor from outside the Continental United States, differ greatly from region to region.

Because the time for effective action is long overdue and because some studies and programs of types recommended by the East Coast Migrant Conference already have been inaugurated on a State basis, the Special Committee urges that interstate conferences be held soon in the other regions but that such conferences be devoted primarily to the problems peculiar to or centering in the individual regions.

Submitted by: Special Committee on Migrant Labor, Association of State and Territorial Health Officers

Special Committee on Migrant Labor

Suggested Specific Studies by the Special Committee and State Health Officers

Action desired:

ADOPTION OF RECOMMENDATION:

THAT THE SPECIAL COMMITTEE ON MIGRANT LABOR OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS REQUEST ALL STATE HEALTH OFFICERS TO SEND TO THE CHAIRMAN BRIEF STATEMENTS AS TO THE NATURE OF THEIR MIGRATORY AGRICULTURAL AND FOOD PROCESSING LABOR PROBLEMS, THE TYPE OF OFFICIAL STATE COMMITTEE OR GROUP DEALING WITH THE PROBLEM, ITS MEMBERSHIP, CHIEF FUNCTIONS OR STUDIES, AND ITS MAJOR RECOMMENDATIONS; AND THAT THE SPECIAL COMMITTEE PREPARE A SUMMARY REPORT AND SET OF COORDINATED RECOMMENDATIONS FOR THE INFORMATION AND GUIDANCE OF THE STATE HEALTH OFFICERS AND REGIONAL CONFERENCES;

THAT THE SPECIAL COMMITTEE ON MIGRANT LABOR OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS COLLECT AND STUDY THE HEALTH RECORD FORMS NOW IN USE BY STATES FOR MIGRATORY AGRICULTURAL AND FOOD PROCESSING LABORERS, THEIR CHILDREN, AND OTHER FAMILY MEMBERS; AND THAT, IN COOPERATION WITH THE PUBLIC HEALTH SERVICE, THE CHILDREN'S BUREAU AND THE OFFICE OF EDUCATION, THE SPECIAL COMMITTEE DEVELOP A BASICALLY UNIFORM SET OF RECORD FORMS, WITH PROVISION FOR DESIRABLE REGIONAL VARIATIONS OR SPECIAL ITEMS OF INFORMATION;

THAT, IN EACH REGION WITH A MIGRATORY AGRICULTURAL AND FOOD PROCESSING LABOR PROBLEM, A TASK FORCE BE APPOINTED BY THE STATE HEALTH OFFICERS TO COLLECT INFORMATION FROM THE STATES IN THE REGION ON EXISTING AND PROPOSED STANDARDS FOR HOUSING AND SANITATION FOR TRANSIENT LABOR; AND TO FORMULATE A SET OF BASICALLY UNIFORM STANDARDS WITH EFFECTIVE GUIDES FOR ADMINISTRATION AND ENFORCEMENT.

Supporting statement:

The proposal that the Special Committee of the Association of State and Territorial Health Officers collect and summarize reports on the official State committees dealing with migratory agricultural and food processing labor problems is an outgrowth of the Association's recommendation in 1953 that each State and Territorial health officer examine the situation in his own jurisdiction and sponsor conferences with other State agencies concerned with the migratory problem. A statement and appendixes on the Colorado committees and programs not only illustrates useful types of information but also suggests the groundwork already laid and the fund of information probably existent in other States.

The proposed development of a uniform set of health record forms by the Special Committee of the Association of State and Territorial Health Officers is in harmony with a recommendation of the East Coast Migrant Conference. This could be done effectively only with the assistance of the federal agencies such as the Public Health Service, Children's Bureau, and Office of Education.

The proposal that regional task forces be appointed to formulate basically uniform standards for housing and sanitation for transient labor is in accordance with a recommendation of the East Coast Migrant Conference, but the Special Committee recommends that such studies be made by each region with migratory labor problems.

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